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Best Practice Guidelines

For Children and Adolescents

Tennessee Department of Mental Health and Developmental Disabilities
Best Practice Guidelines
Behavioral Services for Children and Adolescents

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TDMHDD GUIDELINE

Attention-Deficit/Hyperactivity Disorder

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children between five and twelve years of age with "typical" ADHD in the primary care office. Material herein was prepared by Jerry Heston, M.D., University of Tennessee College of Medicine, based on current understanding of the disorder and coordinated with recommendations from professional organizations, primarily the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry. The goal of the protocol is to improve the care of children with this disorder. It is not intended to dictate treatment decisions but to provide practitioners, especially those in primary care, with information and support as they care for children with ADHD. Complex cases, cases with significant comorbidity or presentations outside the "typical" age range are beyond the scope of this protocol. Nonetheless, the protocol may serve as a base for modifications in these complicated cases.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability.[1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, override the decision of the recipient's guardian or conservator.[2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

In a Child Between Five and Twelve Years Old Who Presents With Chief Complaint(s) of:

School problems
Can't stay in seat
Difficulty taking turns
Can't follow instructions
Difficulty completing tasks
Interrupts, intrudes on others
Accident-prone
Difficulty being calm
Over active: fidgety restless
Easily distracted
Blurts out answers
Disruptive behavior
Talks excessively
Acts without thinking
Poor self esteem
"Someone thinks he has ADHD"

Consider ADHD By Using DSM IV Criteria:

CHECK ALL THAT APPLY:
At least 6 of the following symptoms of inattention have been present for at least 6 months ***to a degree that is maladaptive and inconsistent with developmental level:***

_____ often fails to give close attention to details or makes careless mistakes in schoolwork
_____ often has difficulty in sustaining attention in tasks or play activities
_____ often does not seem to listen when spoken to directly
_____ often does not follow through on instructions and fails to finish schoolwork or chores (not due to oppositional behavior or failure to understand instructions)
_____ often has difficulty organizing tasks and activities
_____ often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (ex: schoolwork, homework)
_____ often loses things necessary for tasks or activities (toys, assignments, pencils, books)
_____ is often easily distracted by environmental stimuli
_____ is often forgetful in daily activities

OR
At least 6 of the following symptoms of hyperactivity and impulsivity have been present for at least 6 months ***to a degree that is maladaptive and inconsistent with developmental level****:*

_____ often fidgets with hands or feet or squirms in seat
_____ often leaves seat in classroom or in other situations in which remaining seated is expected
_____ often runs about or climbs excessively in situations in which it is inappropriate
_____ often has difficulty playing or engaging in leisure activities quietly
_____ is often "on the go" or often acts as if "driven by a motor"
_____ often talks excessively
_____ often blurts out answers before questions have been completed
_____ often has difficulty waiting turn
_____ often interrupts or intrudes on others (butts into conversations or games)

AND
_____ some hyperactive, impulsive or inattentive symptoms *that caused impairment* were present before age 7 years

AND
_____ some impairment from the symptoms is present in two or more settings (ex: school and home)

AND
_____ there is *clear evidence* of clinically significant impairment in social, academic or occupational functioning

AND
_____ the symptoms do not occur only in the course of a pervasive developmental disorder, a psychotic disorder, and/or are not better accounted for by a physiological condition, or by another mental disorder (i.e, Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder)

Confirm Diagnosis Of ADHD With Direct Information From Parents And Teachers Or Other Caregivers:

Request completion of ADHD-specific rating scales (ex.: Abbreviated Conners Scale) by parents and teachers.

Review school-based multidisciplinary evaluations or other school reports and assessments.

Evaluate Presence Of Comorbid Conditions And Differential Diagnoses:

Learning Disabilities may exist where there is irregular achievement in school or when academic functioning is less than might be expected based on service recipient's overall intellect. In about 30% of cases of ADHD, there is an existing learning disability, but it should also be noted that learning disability can often mimic ADHD, especially **inattentive type.** Refer for psycho-educational testing to confirm.

Oppositional Defiant Disorder and **Conduct Disorder** may co-occur with ADHD in about 30% of service recipients. Hallmarks include high levels of defiance or other severely disruptive behavior beyond overactivity and poor attention skills. Consider consultation or referral to mental health care provider for diagnosis and treatment.

Anxiety Disorders with prominent worries, fears and tension may coexist with ADHD. The restlessness and fidgetiness of Anxiety Disorders may resemble ADHD and should be considered in the differential diagnosis. Consider consultation or referral to mental health care provider.

Depressive Disorders may coexist with ADHD, especially in service recipients who have experienced numerous failures or other stresses and have developed depressive thought patterns that begin to influence their outlooks. Some of these children may respond to support and experiencing success instead of failure. Others may require consultation or referral to mental health care provider. Depression is often seen in adolescents with ADHD who may not have been diagnosed and treated properly as younger children so that they have attributed their difficulties to bad behavior or other self problems rather than to a treatable condition. Some of these teens have turned to substance abuse as a means of self-medicating or as a means to a social group. Assessment of substance use/abuse should be included when considering adolescents with ADHD.

Various **social stressors** including adjustment problems, family disruption or physical and sexual abuse can both coexist and resemble the symptoms of ADHD. A careful and complete social history should be completed. Referral to mental health care providers or other agencies may be needed.

Discuss Treatment Options With Service recipient And Family:

Treatment should be **multi-dimensional** and include education, counseling, classroom/school modifications and medication depending on the specific needs of each individual child and family.

The child and parents should be educated about the diagnosis and encouraged to understand that this condition represents a challenge to overcome, not an "excuse" for misbehavior. Strengths and relative weaknesses should be identified. The variations in the presentation and the course of the disorder should be reviewed. Encouraging parents to become advocates for their child and informing them of their options is a part of education that may be done in the primary care office.

MEDICATION THERAPY:

Plan A:
Stimulant medications, either methylphenidate (Ritalin) or amphetamine (Dexedrine, Adderall), are first line medications in the treatment of ADHD. Discuss the indications, possible side effects (decreased appetite, sleep disturbance, headaches, moodiness) and an overall treatment plan with the parents. If consent is obtained begin treatment with low doses of stimulant medication in two to three daily divided doses, each about three to four hours apart (ex: 8AM, 12 N, 4PM).

Based on response and side effects, the dose can be adjusted fairly rapidly, once a week, to a maximum of 2mg/kg/day or 60mg/day of methylphenidate or 1mg/kg/day or 60mg/day of an amphetamine preparation. Most children with ADHD require doses less than the maximum. Lack of response to near maximum doses indicates a need to review the diagnosis and/or consideration of another medication.

Periodic follow up by phone calls and/or office visits should address response, compliance, side effects and overall functioning. Information for school staff is very useful in monitoring response to medications.

If a good response to first line stimulant is documented, changing to a long acting preparation of the same stimulant may be indicated for convenience and improved compliance.

Consideration should be given to "medication holidays"(periods off medication). The indications for these are debatable. However, in consideration of parental desires, the severity of service recipient symptoms (e.g., Is family life disrupted by symptoms? Is peer interaction compromised?) and the activities in which the child participates (example: summer vacation may not be a good time for a medication holiday for a child who is taking classes in summer school) medication-free periods may be desirable. Some knowledge about continued need for medication may be gained during these periods.

If poor response is seen to first line stimulant, go to Plan B.

Plan B:
Lack of response to one stimulant does not indicate poor response to other stimulant medications. Therefore, start treatment with a second stimulant medication (amphetamine, if methylphenidate used in Plan A or vice versa). Methods of dosing and monitoring follow up are as in Plan A.

If poor response is seen, consider Plan C.

Plan C:
Consider treatment with pemoline (Cylert) a third available stimulant. Because of rare, fatal liver toxicity some clinicians may elect to bypass this step. Because of a longer half-life, once a day dosing is possible. Doses begin at 18.75 mg and may be increased in two to three weeks depending on response and side effects. Due to the longer half-life, response may take one to two weeks to occur. Frequent laboratory monitoring of hepatic enzymes (every two to three weeks) can be problematic and limits this option.

Plan D is considered by clinicians that opt against Plan C or for service recipients that do not respond to pemoline.

Plan D:
Tricyclic antidepressant medications have been shown to be useful in children with ADHD. Due to side effects, high overdose toxicity and poorer response rates than stimulants, these medications are thought of as third and fourth line medication interventions. Imipramine (Tofranil) is recommended. Due to possibly higher cardiac effects, desipramine (Norpramin) is not recommended. Pretreatment screening should include family history of cardiac arrhythmias, physical exam, general laboratory screens and an EKG. Side effects (sedation, increased appetite, tremors, and cardiovascular symptoms) are discussed with the service recipient and family. Dosing is started at 25 mg/day in once daily dosing.

The dose is gradually increased based on response and side effects. It may take one to two weeks to observe a clinical response, so dose should not be increased more frequently than weekly. Doses above 2-3mg/kg/day are associated with increased adverse events. Doses higher than this merit reconsideration of the diagnosis and consultation with specialists.

Response, including reports for school staff, should be monitored along with occurrence of side effects and overall functioning. EKG should be monitored throughout treatment, especially at increased doses.

Adjunct Therapies:

Various forms of counseling may be the major intervention for mild cases of ADHD. **Behavioral therapy** can be used to modify behavior using behavioral plans which target specific behavior, outline rewards and address how the plan is to be modified after success. **Family therapy** can be used to change family interactional patterns that may cause dysfunction and improve communication and other family functions to encourage the child with ADHD to rely upon his strengths. Parent training has been proven to be a very effective treatment for children with ADHD, especially when combined with appropriate medications, and parent support groups are an important adjunct to treatment. Various forms of **individual counseling** may be indicated for children with problems coping or other co-morbid conditions (e.g. social skills training). While general behavioral therapy may be done in the primary care office, other, more formal counseling and therapy, should be referred to a mental health care provider.

Consider Referral To Specialist In Developmental Pediatrics Or Child Psychiatry:

Using these guidelines it is estimated that about 90% of children with ADHD will show significant response in the primary care setting (in conjunction with educational and counseling interventions). Lack of response to these interventions indicates need for re-evaluation and possible referral to a specialist in developmental pediatrics or child psychiatry.

TDMHDD GUIDELINE

Anxiety Disorders in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with anxiety disorders in primary care and behavioral health treatment settings. These guidelines are based on the following source material:

> *Practice parameters for the assessment and treatment of children and adolescents with anxiety disorders*. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):69S-84S

The user may wish to refer to the source material for complete text, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with anxiety disorders and aid practitioners in diagnosis and treatment selection.

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1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Differential Diagnosis

Hypoglycemic episodes
Hyperthyroidism
Cardiac arrhythmias
Caffeinism
Pheochromocytoma
Seizure disorders
Migraine
CNS disorders- delirium, brain tumor
Personality disorders
Pervasive developmental disorders
Mood disorders
ADHD
Substance abuse disorders
Eating disorders
Schizophrenia
Medication reaction: antihistamines, antiasthmatics, sympathomimetics, steroids, haloperidol, pimozide, SSRIs, antipsychotics, OTC's (diet pills, cold meds., etc.)

DSM-IV Criteria

Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
B. The person finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months).
Note: Only one item is required in children.
    1. restlessness or feeling keyed up or on edge
    2. being easily fatigued
    3. difficulty concentrating or mind going blank
    4. irritability
    5. muscle tension
    6. sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

Social Phobia

A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. **Note**: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.
B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. **Note**: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
C. The person recognizes that the fear is excessive or unreasonable. **Note**: In children, this feature may be absent.
D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
F. In individuals under age 18 years, the duration is at least 6 months.
G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).
H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

Panic Disorder

A. A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

    1. palpitations, pounding heart, or accelerated heart rate
    2. sweating
    3. trembling or shaking
    4. sensations of shortness of breath or smothering
    5. feeling of choking
    6. chest pain or discomfort
    7. nausea or abdominal distress
    8. feeling dizzy, unsteady, lightheaded, or faint
    9. derealization (feelings of unreality) or depersonalization (being detached from oneself)
    10. fear of losing control or going crazy
    11. fear of dying
    12. paresthesias (numbness or tingling sensations)
    13. chills or hot flushes

B. At least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
   1. persistent concern about having additional attacks;
   2. worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy");
   3. a significant change in behavior related to the attacks

C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

1. recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
2. the thoughts, impulses, or images are not simply excessive worries about real-life problems
3. the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
4. the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

1. repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
2. the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Posttraumatic stress disorder- *(see full guideline in this manual for additional information)*

A. The person has been exposed to a traumatic event in which both of the following were present:
    1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
    2. the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
    1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
    2. recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
    3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
    4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
    5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
    1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
    2. efforts to avoid activities, places, or people that arouse recollections of the trauma
    3. inability to recall an important aspect of the trauma
    4. markedly diminished interest or participation in significant activities
    5. feeling of detachment or estrangement from others
    6. restricted range of affect (e.g., unable to have loving feelings)
    7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
    1. difficulty falling or staying asleep
    2. irritability or outbursts of anger
    3. difficulty concentrating
    4. hypervigilance
    5. exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Other phobias

A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack. **Note**: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.
C. The person recognizes that the fear is excessive or unreasonable. **Note**: In children, this feature may be absent.
D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
F. In individuals under age 18 years, the duration is at least 6 months.
G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder.

Separation anxiety

A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:
    1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
    2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
    3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
    4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation
    5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
    6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
    7. repeated nightmares involving the theme of separation
    8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated
B. The duration of the disturbance is at least 4 weeks.
C. The onset is before age 18 years.
D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.

E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder with Agoraphobia.

Therapy

Behavioral therapy targets the service recipient's overt behavior and emphasizes treatment within the context of family and school instead of focusing on the etiology of the behavior.

Cognitive-behavioral treatment integrates a behavioral approach with an emphasis on changing the cognitions associated with the service recipient's anxiety.

Psychodynamic psychotherapy derives from child psychoanalysis and includes a greater participation of the parents/caregivers and a more explicit use of active support, practical guidance, and environmental interventions. Therapy directed to fears and anxieties underlying the disorder is often an appropriate component of treatment.

Parent-child interventions may include helping parents/caregivers encourage children/adolescents to face new situations rather than withdrawing, refraining from excessive criticism and intrusiveness, responding to children's needs, and encouraging children to engage in activities despite anxiety. Infant-parent psychotherapy is recommended where there are attachment problems.

Family therapy is also used to disrupt the dysfunctional family interactional patterns that promote family insecurity and to support areas of family competence.

Psychoeducation is important in the treatment of panic disorder.

Pharmacological Treatment

Pharmacotherapy should never be used as the sole intervention. Pharmacotherapy should be used only as an adjunct to behavioral or psychotherapeutic interventions. Selection of the appropriate medication is primarily based on comorbid conditions if they exist. For a child/adolescent with ADHD or enuresis, a tricyclic antidepressant is the drug of choice. A child with comorbid obsessive-compulsive disorder would benefit the most from an SSRI. Side effect profile should also be considered when selecting medication therapy.

Benzodiazepines are often used on a short-term basis, and in the case of severe anxiety, benzodiazepines may be used in conjunction with an SSRI or TCA for several weeks until the antidepressant begins to show beneficial effects.

Treatment Steps

1. Determine onset and development of symptoms and the context in which the symptoms occur and are maintained.
   a. Is anxiety stimulus specific, spontaneous, or anticipatory?
   b. Is avoidant behavior present?
   c. Do comorbid symptoms exist?

2. Explore service recipient's developmental history including temperament, ability to soothe self or be soothed, quality of attachment, adaptability, stranger and separation responses, and childhood fears.
3. Obtain medical history, medication history, school history, social history, and family history.
4. Interview service recipient and conduct a mental status exam.
5. Conduct family assessment and evaluate parent-child relationship.
6. Refer for IQ, psychological, learning disability, and speech and language testing if indicated.
7. Establish diagnosis
   a. Consider physical conditions that may mimic anxiety disorders.
   b. Screen for psychiatric disorders that may be comorbid with or misdiagnosed as anxiety disorders.
   c. Consider that more than one anxiety disorder may be present.
8. Education of parents and other significant persons about symptoms, clinical course, treatment options, and prognosis.
9. Consult and collaborate with school personnel.
10. Begin behavioral or psychotherapy depending on the diagnosis.
    a. separation anxiety disorder
       - behavioral program involving child/adolescent, parents, school personnel, and other appropriate persons
       - family interventions including family therapy, parent-child interventions, and parental guidance
       - psychotherapy including cognitive-behavioral therapy and psychodynamic psychotherapy
    b. other anxiety disorders
       - psychotherapy including cognitive-behavioral and behavioral therapy techniques
       - psychodynamic psychotherapy
       - family interventions
    c. social phobia
       - cognitive-behavioral therapy and behavioral therapy
       - individual or group psychotherapy
       - family intervention
    d. other phobias
       - behavioral and cognitive-behavioral therapy
       - complicated cases may require individual and group psychotherapy
    e. panic disorder
       - cognitive-behavioral therapy
       - individual psychodynamic, group, or family psychotherapies
    f. obsessive-compulsive disorder
       - cognitive-behavioral therapy
       - therapist-assisted exposure and response prevention
    g. posttraumatic stress disorder (see also, guideline for PTSD, p. 45)
       - cognitive-behavioral therapy
       - exposure therapy
       - family therapy
       - discussion groups or peer counseling groups

11. Begin pharmacotherapy depending on the diagnosis and severity.
    a. separation anxiety disorder- in severe cases use a benzodiazepine +/- TCA* or SSRI
    b. other anxiety disorders- in severe cases use a benzodiazepine +/- TCA* or SSRI
    c. social phobia- SSRI
    d. other phobias- pharmacotherapy rarely used
    e. panic disorder- SSRI or TCA +/- benzodiazepine
    f. obsessive-compulsive disorder- SSRI or clomipramine
    g. posttraumatic stress disorder- antidepressant of choice

*Trazodone is often effective in these cases.

TDMHDD GUIDELINE

Bipolar Disorder in Children and Adolescents

Introduction

The guideline presented here is designed to assist in the evaluation and treatment of children and adolescents with bipolar disorder symptoms in primary care and behavioral treatment settings. Portions of this guideline are adapted from the following sources:

> Practice parameters for the assessment and treatment of children, adolescents with bipolar disorder. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):157S-177S [120 references]
>
> Treatment algorithms incorporated within this guideline were developed by Catherine Fuchs, M.D., Vanderbilt University Medical Center.

The user may wish to refer to the source material for complete text, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with bipolar disorder and aid practitioners in the difficult task of diagnosis and then choosing the correct treatment for each individual child.

These guidelines are not intended to define or serve as a standard of medical care. Many children and adolescents have comorbid psychiatric disorders, and it is necessary to consider each case individually.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability.[1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator.[2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Differential Diagnosis

Agitated Depression
ADD/ADHD or Conduct Disorder
Schizoaffective disorder
Neurological disorders
Substance-Induced Mood Disorder
Organic affective disorders
Schizophrenia
Posttraumatic stress disorder
Metabolic conditions

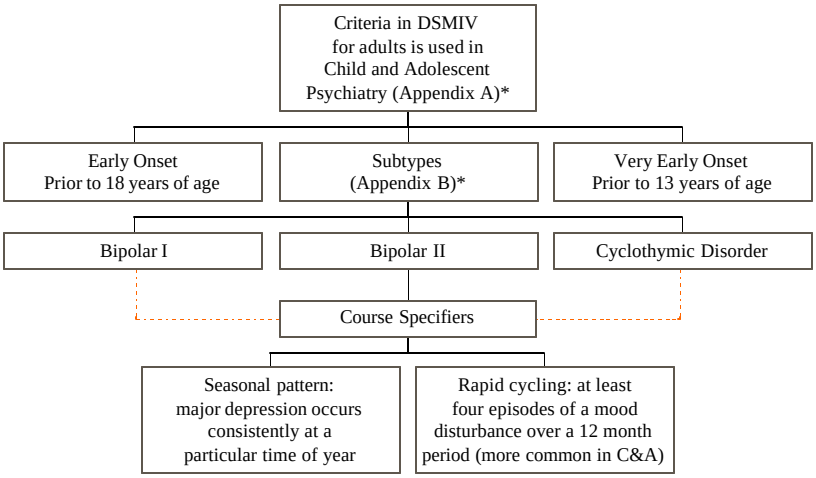
DSM-IV Criteria

A diagnosis of bipolar disorder is made when the required DSM-IV target symptoms for mania/mixed state are present, either currently or by history, and other disorders, such as schizophrenia or organic affective disturbances, have been adequately ruled out. Once the diagnosis has been established, it should be reassessed longitudinally to ensure accuracy.

Specify Subtypes according to DSM IV (Bipolar I, Bipolar II, or Cyclothymic Disorder). Additionally specify early onset if first occurrence is prior to age 18, and very early onset if first occurrence is prior to age 13.

Specify Course of illness. Seasonal pattern is specified if major depression occurs consistently at a particular time of year. Rapid cycling is specified if there are at least 4 episodes of mood disturbance over a 12-month period. Rapid cycling is more common in children and adolescents.

Bipolar Affective Disorder in Children & Adolescents



Exclusion criteria Appendix C*

*Appendices A, B and C refer to DSMIV

Evaluation

Diagnostic Assessment:

- *Premorbid history*
- *History of present illness*
- *Family history and dynamics*
- *School information*
- *Consultation and collaboration with other mental health and/or social service providers as necessary.*
- *Past medical history*

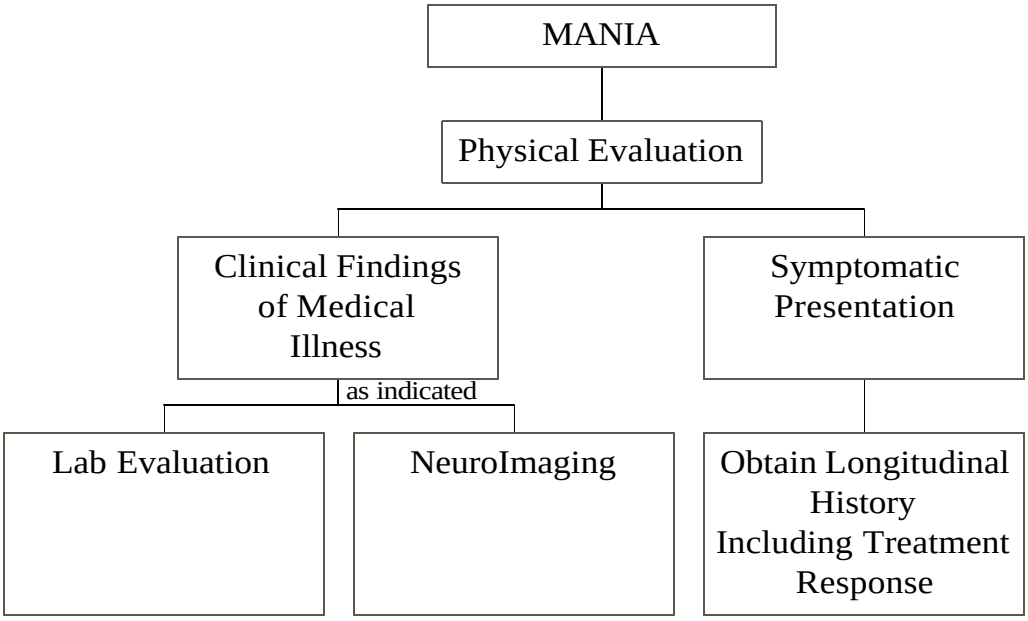
Assessment of suicide risk

Rule out other disorders and determine if necessary to hospitalize

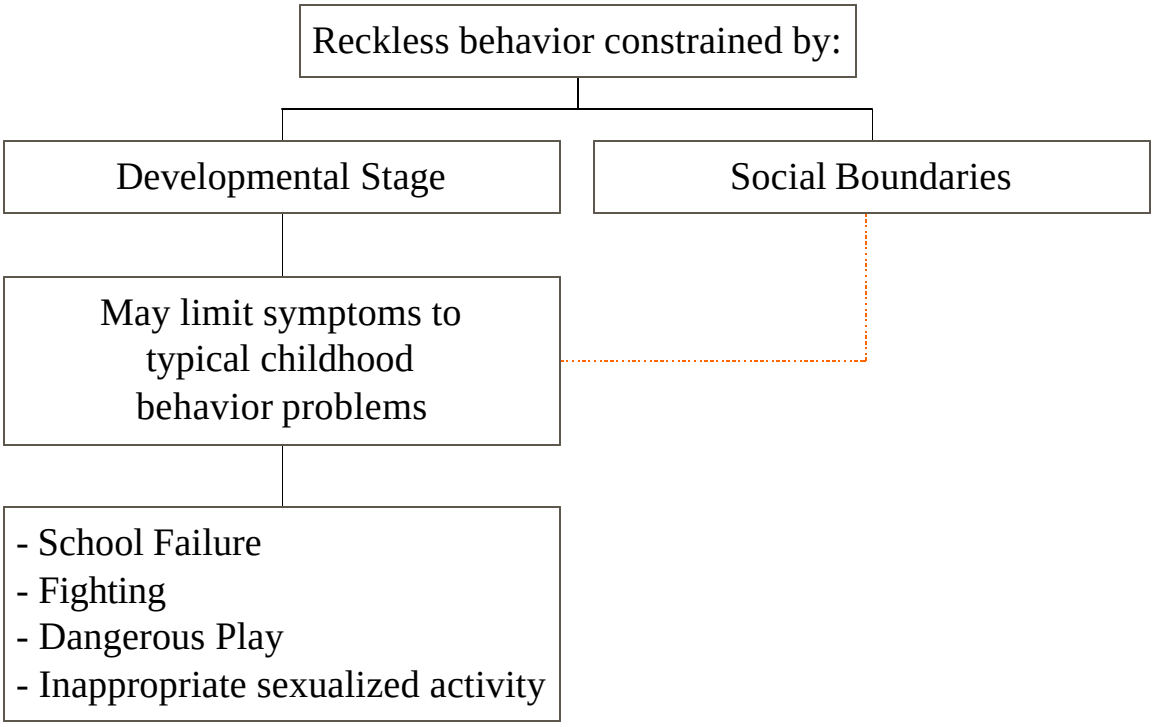
- *Neuropsychological functioning*
- *Substance-induced mood or symptoms*
- *Physical evaluation of the child to rule out organic conditions*

Identify other pertinent issues that will require ongoing treatment (family dysfunction, school difficulties, comorbid disorders).

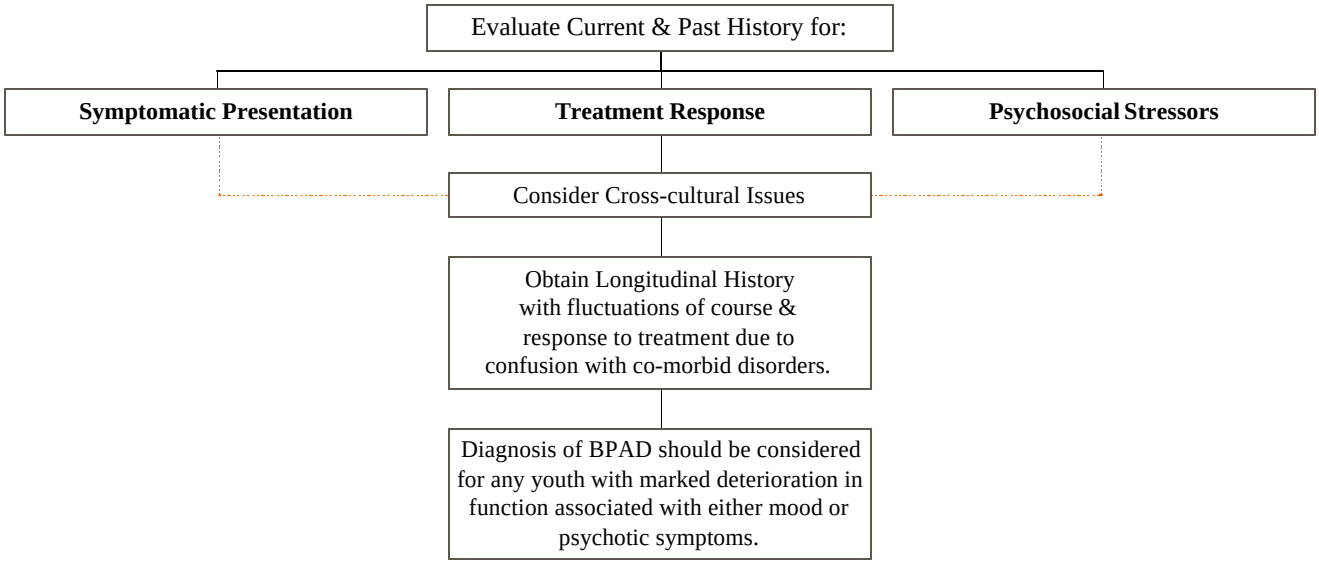
Assessment of Manic Symptoms



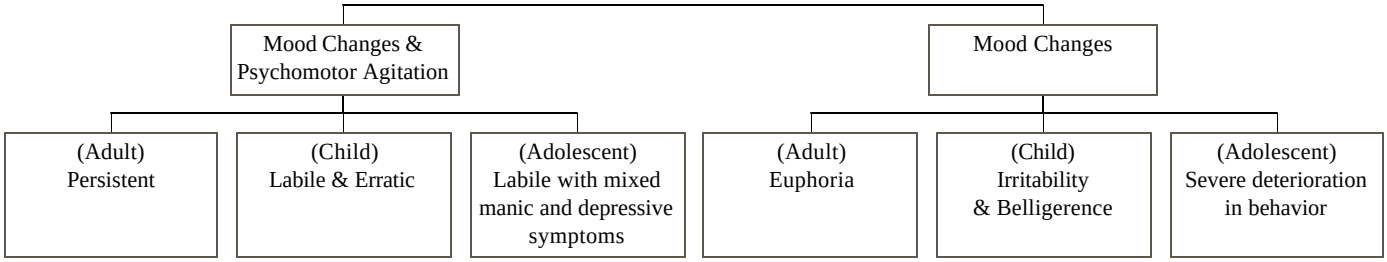
Developmental Issues



Diagnostic Issues



Presentations in Mania



Long Term Treatment Plan

Medication management	Educational and supportive services for the family
Periodic reassessments to ensure accuracy of diagnosis & plan	Educational and vocational services
Appropriate psychotherapy	Case management, as indicated for chronically disabled individuals
Psychoeducational services for the service recipient and family	Residential services when indicated

Medication Therapy

Pharmacotherapy by Symptom Presentations

Symptom Type	**Pharmacotherapy – Primary**	**Pharmacotherapy – Secondary**
In remission	Maintenance Dosage for 18 months	
Rapid Cycling	Depakote or Tegretol individual or in combination (Avoid Antidepressants)	Atypical Antipsychotics
Mixed State	Depakote or Tegretol	If psychotic features - Atypical Antipsychotics
Depression	Depakote, Lithium, or Tegretol	If Persistent Depression – Antidepressants as adjunct only due to risk of inducing mania or rapid cycling
Mania	Lithium – Predicators of poor response – psychosis, mixed state, comorbid behavior disorder or substance abuse	If Partial response - Depakote or Tegretol
Mania (Agitated)	Use above with Benzodizapines for acute phase	If partial response – agitated psychotic, neuroleptics for acute phase

ECT

The use of ECT for persons under eighteen years of age requires strict adherence to procedural safeguards set forth in T.C.A. Title 33, Chapter 8, part 3. Indications and important considerations regarding the use of ECT in children are otherwise discussed fully in the complete AACAP practice Parameter, cited above. A careful reading of both the statute and the practice parameter is necessary to any consideration of this intervention.

Other Treatment Modalities to be considered

Psychosocial therapy

Support, education, and behavioral and cognitive skills training to address the specific deficits of persons with bipolar disorder, to improve functioning and address other problems. Psychodynamic models are not recommended.

Service recipients who have ongoing contact with their families should be offered a family psychosocial intervention that spans at least nine months and provides a combination of education about the illness, family support, crisis intervention, and problem-solving skills training. Such interventions should also be offered to non-family caregivers.

Psychoeducational therapy

- for the service recipient
- for the family

Psychotherapy

- Individual (usually supportive rather than insight-oriented)
- Group
- Family (therapies based on the premise that family dysfunction is the etiology of the service recipient's bipolar disorder *should not* be used.)

Cognitive-behavioral therapy to address inappropriate or negative thought patterns and behaviors associated with the illness.

Treatment of associated disorders or symptoms, such as substance abuse disorder, depression, or suicidality.

Partial hospitalization or day treatment programs Specialized educational and psychiatric services available in either a hospital outpatient setting or a day treatment program that enable the individual to function at home and in community settings.

Residential treatment

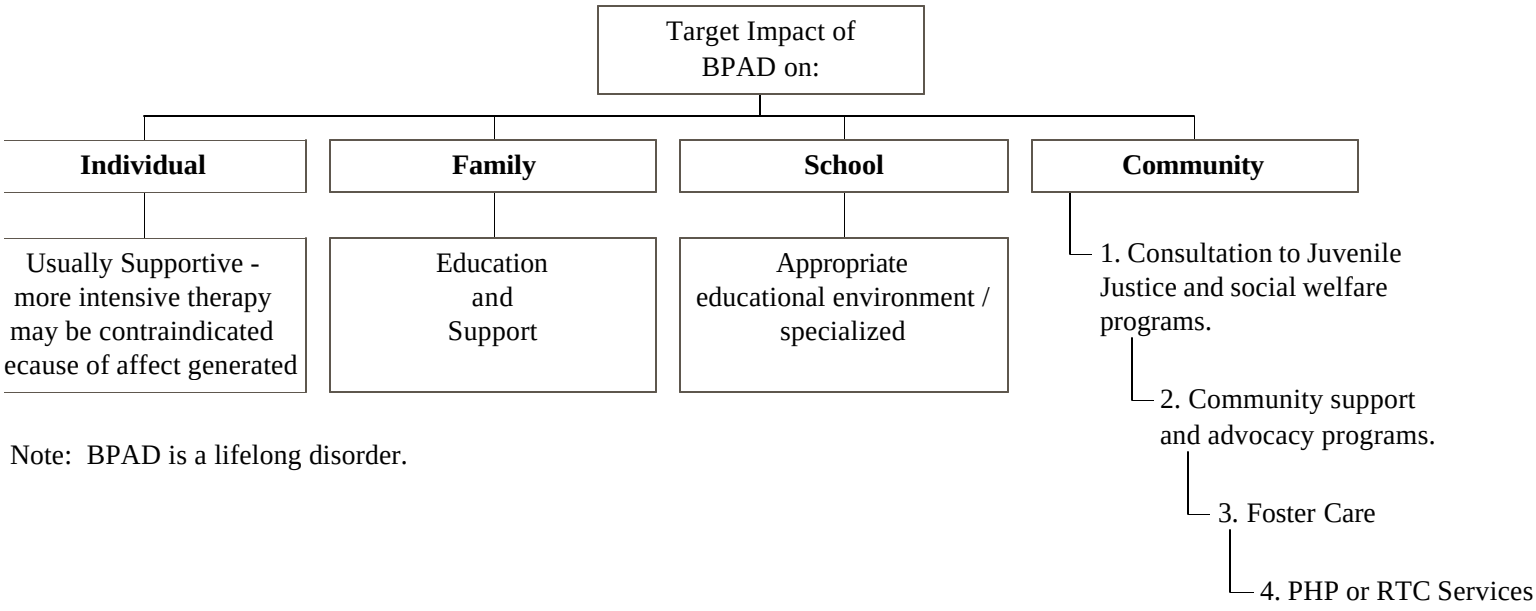
Severe circumstances or poor response to treatment may indicate the need for more restrictive care in an inpatient or residential setting, when less restrictive alternatives have been unsuccessful. Ongoing assessment is needed, and the individual should return to the least restrictive treatment setting practicable, whenever possible.

Psychosocial Rehabilitation

Effective treatment may require a flexible array of services and supports, including case management, in-home services, family support, and school-based services. Supports and services of this kind are individualized and are designed to ameliorate the physical, mental, cognitive or developmental effects of bipolar disorder.

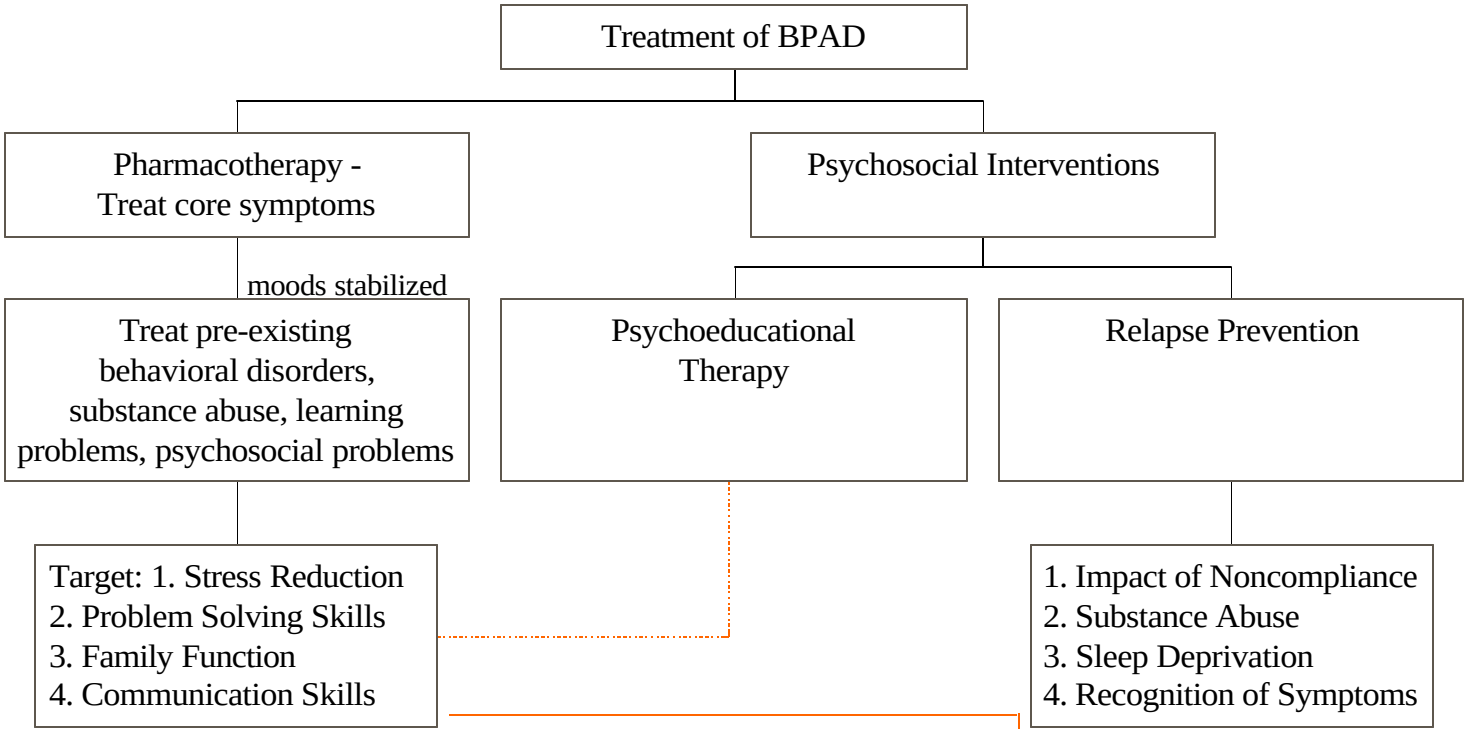
Systems of care serving persons with bipolar disorder who are high service users should include assertive case management and assertive community treatment programs. These programs should be targeted to individuals at high risk for repeated rehospitalizations or who have been difficult to retain in active treatment with more traditional types of services.

Therapy for BPAD

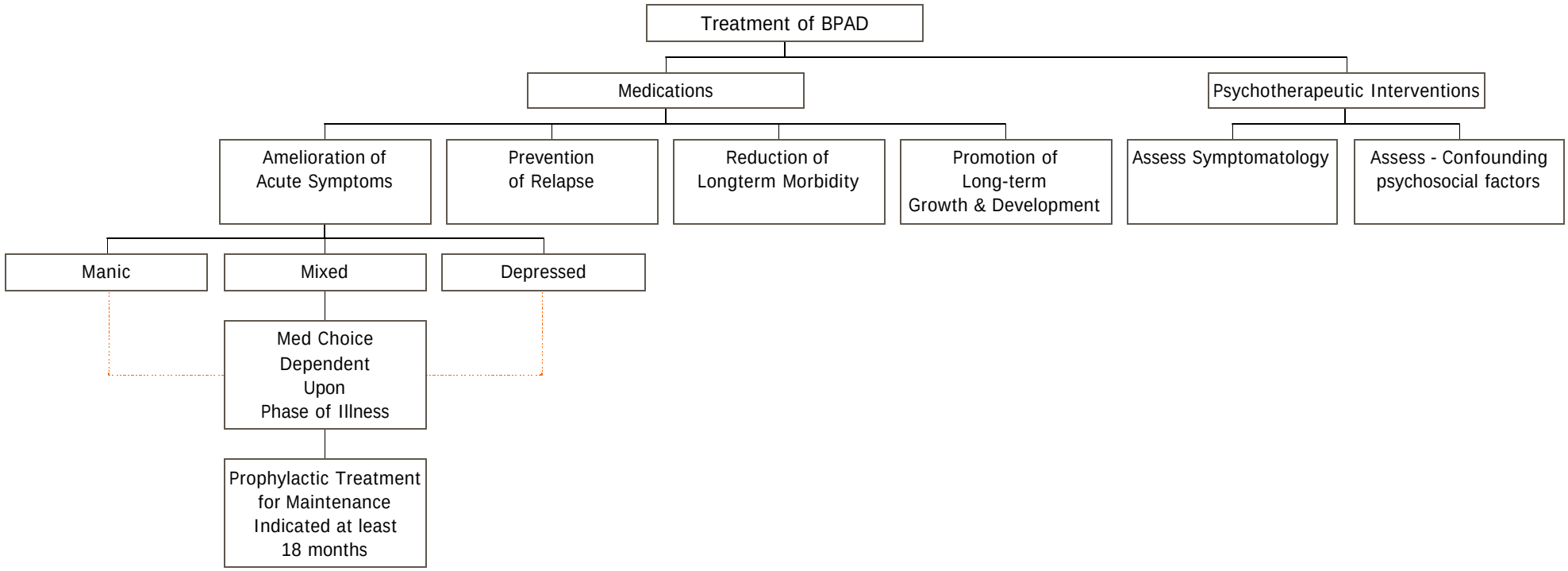


Note: BPAD is a lifelong disorder.

Treatment of BPAD



Treatment of BPAD



TDMHDD GUIDELINE

Evaluation and Treatment of Conduct Disorder in Children and Adolescents

Introduction

The guideline presented here is designed to assist in the evaluation and treatment of children and adolescents with conduct disorder in primary care and behavioral treatment settings. Portions of this guideline are based on the following sources:

> *Practice parameters for the assessment and treatment of children and adolescents with conduct disorder.* J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):122S-139S
>
> Decision trees and essential outline materials were furnished by Martha Wike, Ph.D., Consulting Psychologist, Tennessee Department of Children's Services

The goal of this protocol is to improve the care of children/adolescents with conduct disorder and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Differential Diagnosis

Oppositional defiant disorder	Adjustment disorder
ADHD (may be comorbid)	Mood disorders (may be comorbid)
Substance abuse (may be comorbid)	Child or adolescent antisocial behavior (see DSM-IV v71.01)
Medical disorders	Developmental disorders
PTSD	Schizophrenia
Personality disorders*	

* According to DSM-IV, Antisocial Personality Disorder cannot be diagnosed in a person under age eighteen; other personality disorders must have been pervasive and persistent for at least one year to be diagnosed in someone under age eighteen.

DSM-IV Criteria

Conduct Disorder, as defined by the DSM-IV, consists of a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past six months:

- Must have three (3) or more:

→ Aggression to people or animals
→ Destruction of property
→ Deceitfulness or theft
→ Serious violation of rules

- The disturbance in behavior causes clinically significant impairment
- If eighteen or older, not Antisocial Personality

Assessment

- **Service recipient** interview (with and without parents) **…**assess mental status, impulse control, capacity for attachment, trust and empathy, tolerance for negative emotions
- Parent interview **…**assess developmental hx, family hx of mood and thought disorders, impulse control and substance abuse disorders, personality disorders
- Collateral contact interviews (school, court)
- Physical exam, including urine or blood drug screen, if drug use is suspected

Treatment

Treatment should be provided in a continuum of care that allows flexible application of modalities by a cohesive treatment team. Outpatient treatment of conduct disorder includes intervention in the family, school, and peer group. Typically, several of the following treatment modalities are used in conjunction in order to provide a comprehensive model. Wrap-around approaches, Multi-Systemic Therapy (MST) and Continuing Comprehensive Family Treatment (CCFT) are all noted as effective approaches to Conduct Disorder.

- Treat comorbid disorder

- *Family interventions* include parent guidance, skills training and family therapy.

→ Work on parenting strengths **…**eliminate too harsh and too permissive approaches
→ Treat parental pathology

- *Individual and group psychotherapy* with adolescent or child. The technique of intervention should be adapted to child's age, processing style, and ability to engage in treatment.

→ Group therapy is important with adolescents
→ Individual therapy, alone, is ineffective

- *Psychosocial skill-building training*.

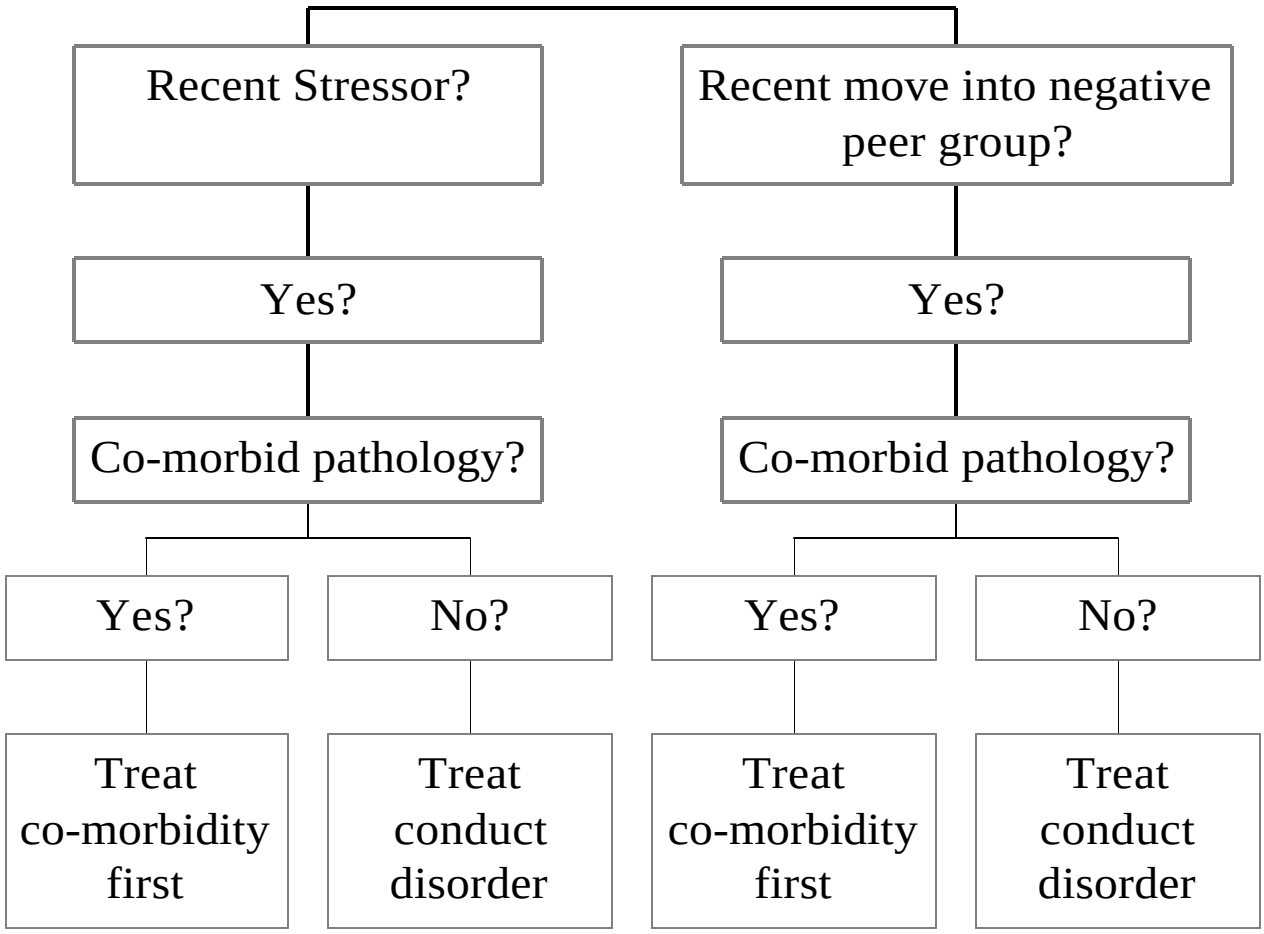
→ Child training to improve peer relationships
→ Child training to improve academic skills
→ Child training to improve compliance with demands from authority figures
→ Social skills building

- *Other psychosocial interventions* should be considered as indicated. Some interventions to consider are peer intervention, school intervention for appropriate placement, juvenile justice system intervention, social services, community resources, out-of-home placement, and job and independent-living skills training.

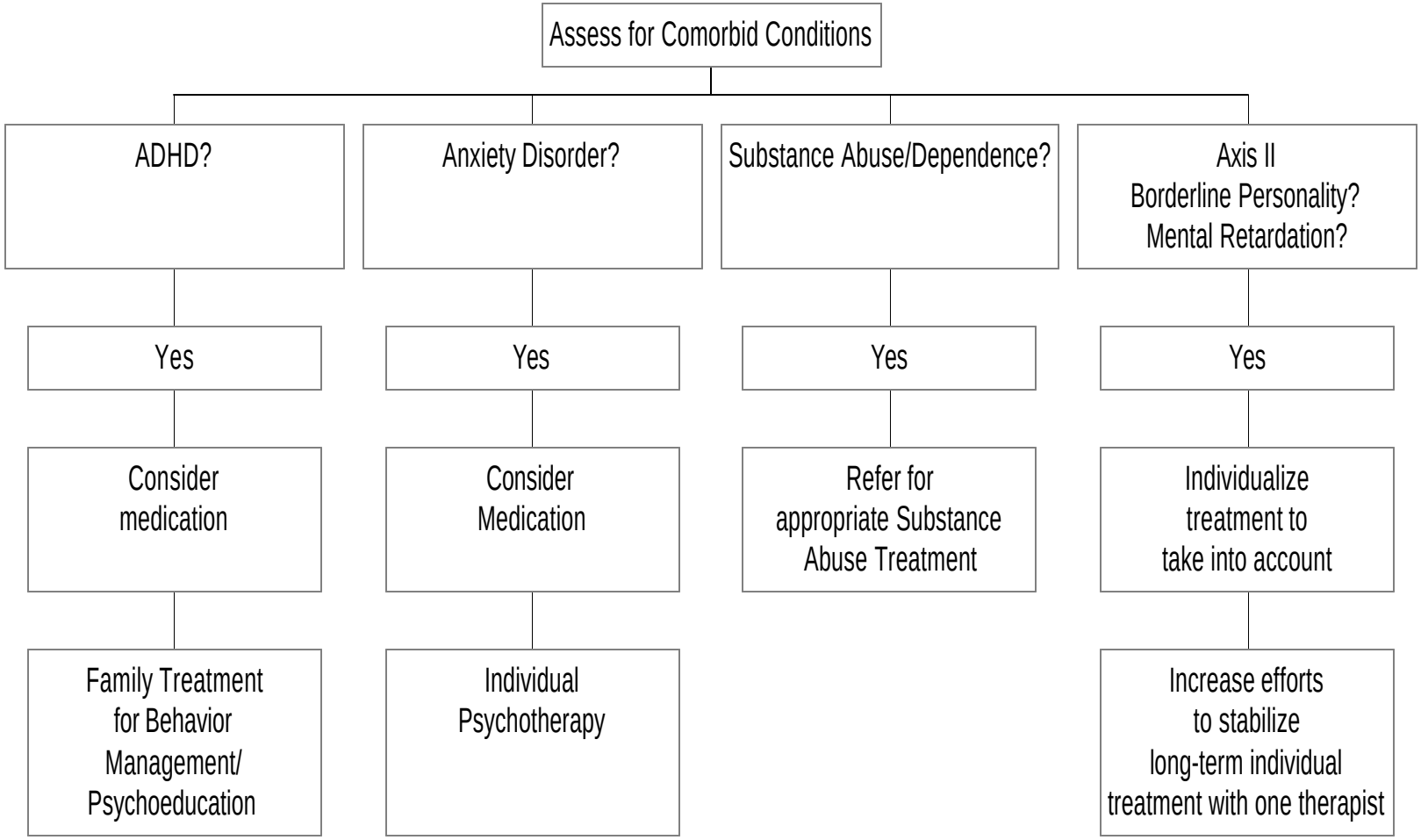
- *Psychopharmacology*. Medications are recommended only for treatment of target symptoms and comorbid disorders and are recommended only on the basis of clinical experience.

- *Level of care decision-making*. Level of care should be the least restrictive level of intervention that fulfills both the short and long-term needs of the service recipient.
-

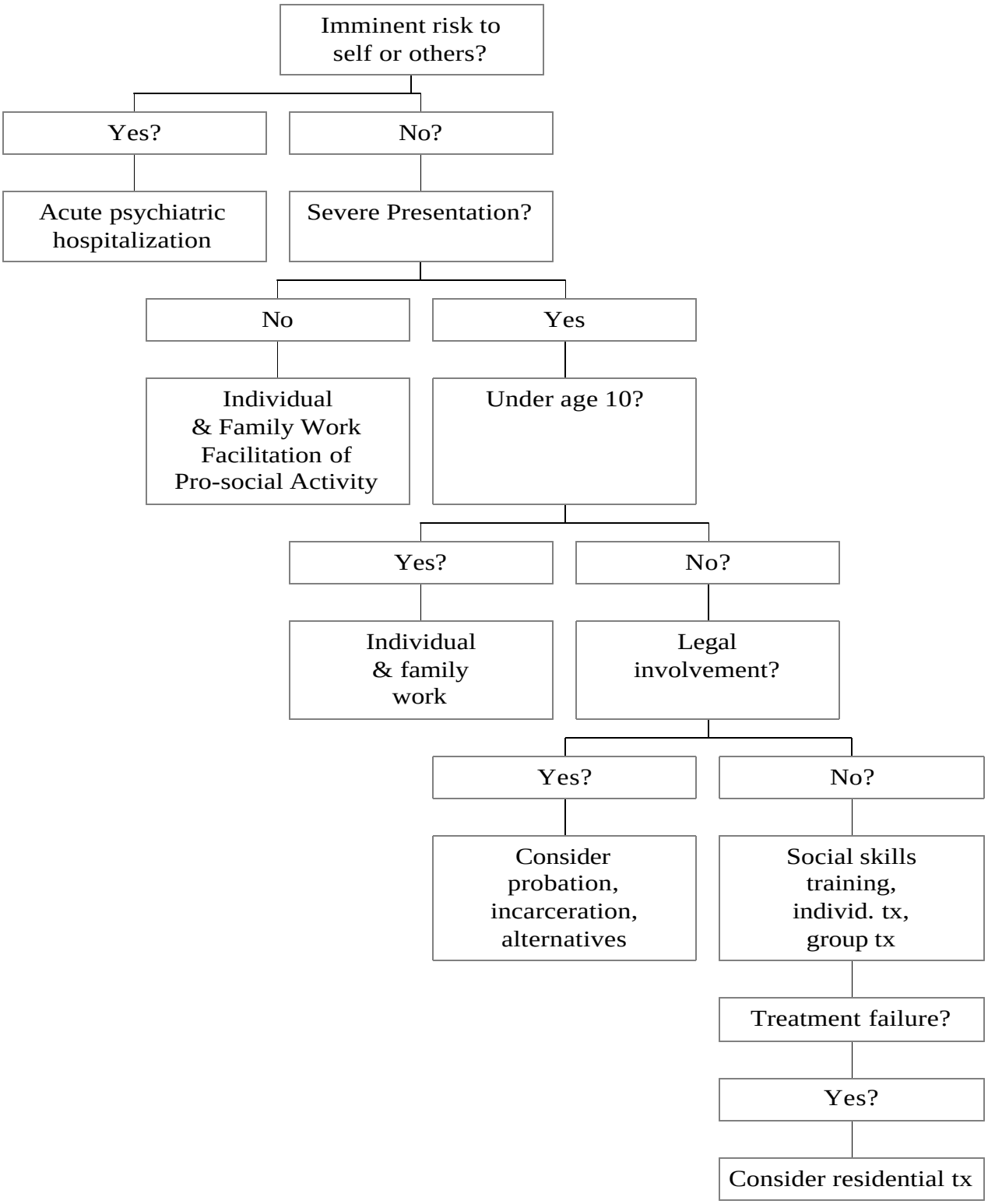
Decision Tree for Conduct Disorder



Assessment


Assess for Comorbid Conditions
ADHD?
Anxiety Disorder?
Substance Abuse/Dependence?
Axis II
Borderline Personality?
Mental Retardation?
Yes
Yes
Yes
Yes
Consider
medication
Consider
Medication
Refer for
appropriate Substance
Abuse Treatment
Individualize
treatment to
take into account
Family Treatment
for Behavior
Management/
Psychoeducation
Individual
Psychotherapy
Increase efforts
to stabilize
long-term individual
treatment with one therapist

Conduct Disorder Treatment



TDMHDD GUIDELINE

Depression in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with depressive disorders in primary care and behavioral treatment settings. These guidelines are adapted from:

> *Practice parameters for the assessment and treatment of children and adolescents with depressive disorders.* J Am Acad Child Adolesc Psychiatry 1998 Oct;37(10 Suppl):63S-83S [231 references]

The user may wish to consult the source material for complete texts, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with depression and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inservice recipient mental health service providers to maintain treatment review committees for service recipients admitted to inservice recipient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Assessment

- Comprehensive psychiatric diagnostic evaluation, including interviews with the child, parents, and collateral informants, such as teachers and social services personnel
- Evaluation performed by a clinician trained to consider how developmental and cultural factors impact the service recipient's clinical presentation
- Performance of a developmentally appropriate mental status examination (MSE), physical examination, laboratory tests

- Use of standardized depression checklists such as the Children's Depression Inventory (CDI) and the Beck Depression Inventory (BDI)
- Assessment of risk for suicidal behaviors
- Global functioning assessment using scales such as the Children's Global Assessment Scale or the Global Assessment of Functioning
- Identification of other pertinent issues that will require ongoing treatment (family dysfunction, school difficulties, comorbid disorders)
- Ongoing assessment

Differential Diagnosis

Anxiety disorders	Chronic fatigue syndrome
Learning disabilities	Bereavement
Disruptive disorders	Anorexia nervosa
ADHD	Premenstrual dysphoric disorder
Substance abuse	Bipolar disorder
Personality disorder	Eating disorders
Medical disorders	Domestic violence, sexual and physical abuse issues
Adjustment disorder	Sexual identity and orientation issues in adolescence

DSM-IV Criteria for Major Depressive Disorder

Major Depressive Disorder (MDD), in general consists of:

- One or more Major Depressive Episodes, as defined below,
- Not better accounted for by Schizoaffective Disorder, and not superimposed on Schizophrenia, Schizophreniform, Delusional, or Psychotic Disorder, **and**

There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode (except as may have been induced by substance, treatment, or due to the direct physiological effect of a general medical condition).

A Major Depressive Episode, as defined by the DSM-IV, consists of either a depressed or irritable mood and/or a loss of interest or pleasure for at least 2 weeks, in addition to the presentation of 5 or more of the following symptoms:

• DEPRESSED MOOD MOST OF THE DAY, NEARLY EVERY DAY • MARKEDLY DIMINISHED INTEREST IN ACTIVITIES, MOST OF THE DAY, NEARLY EVERY DAY • SIGNIFICANT WEIGHT LOSS/WEIGHT GAIN • INSOMNIA/HYPERSOMNIA	• PSYCHOMOTOR RETARDATION OR AGITATION • DECREASED ENERGY OR MOTIVATION • GUILT FEELINGS • INABILITY TO CONCENTRATE • RECURRENT THOUGHTS OF DEATH OR SUICIDAL IDEATION, SUICIDE ATTEMPT OR PLAN

AND these symptoms:

• SOCIAL IMPAIRMENT OR IMPAIRMENT IN PERFORMANCE OF ACTIVITIES • UNRELATED TO SUBSTANCE ABUSE	• UNRELATED TO BEREAVEMENT • UNRELATED TO MEDICATION USE OR OTHER PSYCHIATRIC ILLNESS

Treatment

Treatment Planning

- Develop treatment plan appropriate to developmental stage of child or adolescent
- Provide services in the least restrictive environment that provides safety and effectiveness

Acute Treatment

- The choice of initial therapy depends on

  - ♦ Chronicity
  - ♦ Severity and number of prior episodes
  - ♦ Contextual issues
  - ♦ Previous response to treatment
  - ♦ Age of service recipient
  - ♦ Compliance with treatment
  - ♦ Service recipient's and family's motivation for treatment

- Pharmacotherapy alone usually is not sufficient.

- The high degree of comorbidity and the severity of psychosocial and academic consequences of depression suggest a multi-modal treatment approach.

- Because depression usually runs in families it is important to assess and treat other family members and those who live with the service recipient.

Service recipient and Family Education

The service recipient and caregivers should be taught about the disease and the treatment involved. Family education involves family members as informed partners in the treatment team, and helps them understand depression as an illness, identify and manage affect, address psychosocial deficits, and learn the importance of compliance with treatment. Participation by parents may help them identify their own depressive symptoms.

Psychotherapy

- *Cognitive-Behavioral Therapy (CBT)* is based on the premise that depressed service recipients have cognitive distortions in how they view themselves, the world, and the future; that these cognitive distortions contribute to their depression. CBT teaches service recipients to identify and counteract these distortions. Clinical studies found a high rate of relapse upon follow-up, suggesting the need for continuation treatment.

- *Interpersonal Therapy (IPT)* focuses on problem areas of grief, interpersonal roles, disputes, role transitions, and personal difficulties. IPT has been shown to be useful in the acute treatment of adolescents with MDD. The rate of relapse may be relatively low after acute IPT treatment.
- *Psychodynamic psychotherapy* can help youth understand themselves, identify feelings, improve self-esteem, change maladaptive patterns of behavior, interact more effectively with others, and cope with ongoing and past conflicts.
- *Family Therapy* may be indicated where there is a history of substance abuse in the family, or domestic abuse, divorce, or similar stressors. Because depression usually runs in families it is also important to assess and treat other family members and those who live with the service recipient.
- *Group Therapy* may be indicated for adolescents and older children.
- *Expressive Therapy* (i.e. play, art, writing) is recommended by many clinicians to facilitate a child's ability to identify and process difficult feelings and issues.

Antidepressant Medication

Pharmacotherapy alone is never sufficient as the sole treatment. Combined treatment promotes self-esteem, coping skills, adaptive strategies, and improved peer and family relationships.

Antidepressant medications seem indicated for children and adolescents with severe symptoms that prevent effective psychotherapy; whose symptoms fail to respond to an adequate trial of psychotherapy; with chronic or recurrent depression; and with psychotic or bipolar depressions.

Prior to initiating treatment, specific target symptoms should be defined with the service recipient and parents. They should be informed about side effects, dose schedule, the lag in onset of therapeutic effect, and the danger of overdose. Parents should maintain responsibility for storing and administering the medications to enhance compliance and minimize suicidal risk from overdose. Quantity of dispensed medications should be monitored carefully.

Selective serotonin reuptake inhibitors (SSRIs) are the initial antidepressants of choice for service recipients requiring pharmacotherapy, although the presence of comorbidities may require alternate initial agents or a combination of medications. There is no indication for laboratory tests before or during the administration of SSRIs.

SSRIs are the drugs of choice because of their safety, side effect profile, ease of use, and suitability for long-term maintenance. Since improvement with the SSRIs may take 4 to 6 weeks, service recipients should be treated with adequate and tolerable doses for at least 4 weeks. At 4 weeks, if service recipients have not shown even minimal improvement, treatment should be modified (e.g., increase dose, change medications). If the service recipient shows improvement at 4 weeks, the dose should be continued for at least 6 weeks. The SSRIs have a relatively flat dose-response curve, suggesting that maximal clinical response may be achieved at minimum effective doses.

Tricyclic Antidepressants are not recommended as first line treatment for youth with depressive disorders because of the lack of efficacy and potential side effects. Nevertheless, individual service recipients may respond better to the Tricyclic Antidepressants (TCAs) than other medications. If TCAs are used, baseline electrocardiogram (EKG), resting blood pressure and pulse (supine or sitting, standing), and weight should be monitored regularly.

Augmentation agents may be indicated for children who are resistant to treatment or present complicating factors. Such agents may include:

- Trazodone
- Anticonvulsants
- Antimania medication
- ECT (only as authorized by statute. See T.C.A. 33-8-301 et seq.)
- Antipsychotic medication (for MDD with psychotic features)*

  * See guideline on treatment of Schizophrenia for additional information on antipsychotic medication

Continuation Phase

- Continuation therapy is recommended for all service recipients for at least 6 months after remission.
- The service recipient and his or her family should be taught to recognize early signs of relapse.
- Continuation psychotherapy helps to foster medication compliance.
- Antidepressants must be continued at the same dose used to attain remission of acute symptoms.
- At the end of the continuation phase, for service recipients who do not require maintenance treatment, medications should be discontinued gradually.

Maintenance Therapy

Clinicians should consider maintenance therapy for service recipients with multiple or severe episodes of depression and those at high risk for recurrence. Factors associated with recurrence include a family history of bipolar disorder or recurrent depression, comorbid psychiatric disorders, stressful or non-supportive environments, and residual or subsyndromal symptomatology.

The treatments that were used to induce remission in the acute phase should be used for maintenance therapy. Youth with two or more episodes of depression should receive maintenance treatment for at least 1 to 3 years. Service recipients with recurrent episodes accompanied by psychosis, severe impairment, severe suicidality, and treatment-resistance, as well as service recipients with more than 3 episodes, should be considered for longer, even lifelong treatment.

The long-term effects of antidepressants on maturation and development of children have not been studied. The clinician and service recipient's family should therefore weigh the risks and benefits of pharmacotherapy in maintenance therapy.

DYSTHYMIC DISORDER

DSM-IV Criteria for Dysthymic Disorder (child or adolescent)

- Depressed Mood, most of the day, more days than not, for at least one year
- Presence, while depressed, of two or more of the following
  - ♦ poor appetite or overeating
  - ♦ low energy or fatigue
  - ♦ low self-esteem
  - ♦ poor concentration or difficulty making decisions
  - ♦ feelings of hopelessness

- The foregoing symptoms have not abated for more than 2 months at a time during the year.
- The disturbance is not better accounted for by MDD.
- There has never been a manic, mixed, or hypomanic episode.
- The disturbance does not occur exclusively in the course of a Psychotic Disorder.
- The symptoms are not due to physiological effects of substance use or a general medical condition.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Treatment

Clinical practice and theory support the use of psychotherapies of varying degrees of intensity to treat Dysthymic Disorder (DD). In the absence of published studies of psychotherapeutic or pharmacologic treatment of children and adolescents with DD or comorbid MDD and DD, clinicians are advised to use interventions recommended for the treatment of youth with MDD.

PREVENTION

Youth with subclinical depressive symptoms are at high risk to develop clinical depression. When these symptoms persist after an episode of depression, continuous treatment until full remission is recommended. For service recipients who have not had an episode of depression, psychosocial interventions to reduce environmental and family stressors and CBT strategies appear to be efficacious to prevent deterioration.

Children with DD usually have a first episode of MDD 2 to 3 years after the onset of the DD, suggesting that DD is a gateway to recurrent mood disorders and indicating the need for early intervention with mild to moderate depression. Early intervention with depressed youth also may avert the development of comorbid psychiatric disorders. For example, MDD often precedes the onset of substance use disorders and treatment of depression may prevent their development.

TDMHDD GUIDELINE

Mental Retardation and Comorbid Disorders In Persons Under 22 Years of Age

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents who have mental disorders comorbid with mental retardation (MR). These guidelines are adapted from the following sources:

> *Practice parameters for the assessment and treatment of children, adolescents, and adults with mental retardation and comorbid mental disorders*. J Am Acad Child Adolesc Psychiatry 1999 Dec;38(12 Suppl):5S-31S [117 references]
>
> Rush AJ, & Frances A,. eds. *The Expert Consensus Guideline Series: Treatment of Psychiatric and Behavioral Problems in Mental Retardation*. American Journal on Mental Retardation 2000;105:159-228.

The user may wish to refer to the source material for complete text, annotations, and references.

Goals of this Protocol:

1. To improve the care of children/adolescents, and young adults up to twenty-one to twenty-two years of age (an upper age limit of eligibility for public special education and related services in some states), who present mental retardation and possible comorbid disorders.

2. To aid practitioners in the difficult task of assessment and then choosing the correct treatment for each individual child. These guidelines are not intended to define or serve as a standard of medical care. Clinical management recommendations herein do not replace clinical judgement, tailored to the particular needs of each clinical situation.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Assessment and Diagnosis

Overview

Psychiatric and behavioral assessment of persons with MR includes:

- Comprehensive assessment of MR
- Assessment of mental illness in persons with mental retardation, including comprehensive history, service recipient interview, medical review and diagnostic formulation.

Diagnosis of MR (Considerations, based on DSM-IV and AAMR criteria)

Criteria	Definition	
Significantly sub-average intellectual functioning	IQ approximately 70 or below	
Below average IQ causes limitations in adaptive skills* and functioning in at least two of the following areas:	Communication, Self-direction, Self-care, Functional academic skills, Home living, Work, Social/interpersonal skills, Leisure, Use of community resources, Health and safety	
Age at onset	Must be evident before age 18	
Levels of serverity (DSM-IV)	Mild Moderate Severe Profound Unspecified	IQ 55-70 IQ 40-55 IQ 25-40 IQ below 25 Strong presumption, but the individual's intelligence is untestable by standard instrument
Levels of supports needed (AAMR)	Intermittent, Limited, Extensive, or Pervasive	
Be cautious in interpreting low IQ in the presence of a psychiatric disorder	Impairment in IQ must precede and not be directly related to psychiatric disorder	

***** *as identified from, e.g., the Vineland Adaptive Scales*

Assessment of Mental Illness in Persons with MR

Mental illness is frequently comorbid with mental retardation, with most prevalence estimates ranging from 30% to 70%. Virtually all categories of mental disorders have been reported in this population.

However so, diagnostic precision, in the presence of MR, is not always feasible. There is strong consensus opinion that specific psychiatric diagnosis is not routinely and reliably possible in more severe cases of MR. Many practitioners use medication only when there is a specific psychiatric diagnosis.

The psychiatric diagnostic evaluation of persons who have MR is in principle the same as for persons who do not have mental retardation. The diagnostic approaches are modified, depending on the service recipient's cognitive level and especially communication skills. For persons who have mild MR and good verbal skills the approach does not differ much from diagnosing persons with average cognitive skills. The poorer the communication skills, the more one has to depend on information provided by caregivers familiar with the service recipient and on direct behavioral observations.

Assessment Methods

Preferred methods of evaluation

Interview with family/caregivers	Direct observation of behavior
Medical history and physical examination	Functional behavioral assessment
Medication and side effects evaluation	Unstructured psychiatric diagnostic interview †

Also consider:

- Standardized rating scales (e.g. SCID, BDI)
- Biomedical evaluation, including family, pregnancy, perinatal, developmental, health, social, and educational history; physical and neurodevelopmental examination; and laboratory tests. Laboratory tests are usually indicated by the findings in the history and physical examination and may include chromosomal analysis (including fragile-X by DNA analysis); brain imaging (CT scan, MRI); EEG; urinary amino-acids; blood organic acids and lead level; appropriate biochemical tests for inborn errors of metabolism.
- Standardized testing (e.g. intelligence, neuropsychological, language) ††

† *first line for mild/moderate MR, but not severe/profound MR*

†† *in mild/moderate MR Only*

Recipient and Caregiver Interview

The recipient may present communication deficits or may otherwise be shy in regard to disclosure of relevant history. Information from parents and caregivers should always be sought in order to develop a more complete assessment, especially in those instances where the recipient lacks adequate communication skills. Attempts should be made to collect both anecdotal subjective information and more objective data, such as the Vineland Adaptive Scales, daily record keeping, or graphical data.

Comprehensive History Includes:

- Presenting symptoms/behaviors
- Assessment of functioning
- Treatment history
- Placements and supports
- Family/household dynamics
- Past evaluations

Recipient Interview:

- Ample time should be allotted for the service recipient interview. Sufficient time is needed to put the service recipient at ease.
- The interview should be adapted to the service recipient's communication skills.
- Clear and concrete language should be used.
- Reassurance and support should be provided.
- Leading and yes/no questions should be avoided.
- The interviewer should attempt to ensure that questions are understood.
- Mental status may be assessed from context of conversation, rather than by formal examination.
- Nonverbal expression and activity should be considered.

Medical Review

- Developmental history
- Medical history
- General medical disorders and treatments

Evaluation of Stressors

Complete evaluation and individualized treatment requires attention to possible stressors that may be triggering or exacerbating the presenting problem in someone with MR. The stressors listed below may be more likley to occur in persons with MR, and cause difficulties for those who have reduced coping skills. Helping the individual, family, and caregivers deal with or eliminate stressors may sometimes be the primary target of treatment and often facilitates whatever other treatment interventions are necessary.

Type of Stressor	Examples
Change	Moving, new school or job, change of routine, developmental milestones, ***transition from developmental centers***
Interpersonal	Loss of significant other, displacement from job or school
Environmental	Crowding, noise, disorder, lack of stimulation, lack of privacy, work or school-related pressure
Parenting/Social Support	Lack of support from others; disruptive visits/contacts; neglect, hostility, physical or sexual abuse
Illness/Disability	Chronic illness, serious acute illness, sensory deficits, difficulty with ambulation, seizures
Stigmatization problems	Being taunted, teased, excluded, bullied, or exploited
Frustration	Inability to communicate needs & wishes; lack of choice in living & work situations; self-awareness of deficits
Trauma	***Persons with mental retardation have higher rates of victimization***

Treatment

Generally

The habilitation of persons with MR is based on the principles of normalization and community based care, with additional supports as needed. Federal legislation, for example, the Individuals with Disabilities Education Act (IDEA), entitles disabled children and adolescents to a full range of diagnostic, educational and support services from birth to age 21. Specialized treatments are also provided if necessary, as is done for persons with severe visual and auditory impairment.

The parents of children and adolescents with MR are entitled by these laws to receive support services and to be active participants in treatment planning. Some parents and older service recipients are not aware of their rights to obtain services. The clinician has an important role in such instances to educate and, if needed, to refer to a "patient advocate" or "educational advocate."

In recent practice, children and adolescents are educated in special classes in regular school or in inclusionary programs (in age appropriate regular classes, with additional supports as needed). In the United States, children with MR are now rarely if ever placed in residential institutions and separate schools. Adults with MR of all levels live in the community, in settings varying from their own apartments with supports as needed, to small shared living situations. They are employed in specialized settings or, increasingly, in the competitive job market. Habilitation and treatment include:

- Specific treatment of the underlying condition, if known, to prevent or to minimize brain insults that result in MR (e.g., shunting in the case of hydrocephalus).

- Early intervention, education, and ancillary therapies (such as physical, occupational, language therapies, ***and behavior therapies***), family support, and other services, as needed.

- Treatment of comorbid physical conditions, such as hypothyroidism, congenital cataracts or heart defects in children with Down syndrome, treatment of seizures in persons with tuberous sclerosis, etc.

- Psychiatric treatment of comorbid mental disorders, including psychosocial interventions and pharmacotherapy.

Psychiatric Treatment

The approach to treatment of mental illness in persons with MR is generally the same as for persons without MR. Modifications of treatment may be necessary, according to the individual's circumstance. Persons with Down Syndrome, e.g., may be exquisitely sensitive to anticholinergic drugs, and some persons with MR may be more sensitive to the disinhibiting effects of sedative/hypnotic agents.

Medical, habilitative, and educational interventions should be coordinated within an overall treatment program. Medication should be integrated as part of a comprehensive treatment plan that includes, appropriate behavior planning, behavior monitoring, and communication between the prescribing physician, therapists, and others providing supports, habilitative services, and general medical treatment.

Medication decisions should be appropriate to the diagnosis of record, based upon specific indications, and not made in lieu of other treatments or supports that the individual needs. There should be an effort, over time, to adjust medication doses to document ongoing need or the minimum dose at which a medication remains effective.

Medication decisions need to be based upon adequate information, including medication history and consideration of the individual's complete, current regimen. Medication decisions need to be made with due consideration for potential problems of polypharmacy, and otherwise for negative impact on the individual's functioning and overall quality of life. Every effort should be made to avoid unnecessary compromise of cognitive function or exacerbation of ataxia. Risk vs. benefit needs to be considered and continually reassessed, and justification should be provided, where the benefit of a medication comes with certain risks or negative consequences.

Behavioral Emergencies

- Restraint of any kind, where permitted, is used only when efforts at redirection have failed and the service recipient poses an imminent risk of harm to self or others.
- Emergency medications, where permitted, are given only after appropriate diagnostic assessment and other alternatives are contraindicated.
- Possible medical causes for an acute behavioral exacerbation must be considered (e.g., other illness, injury, medication side effects).
- Reassessment of the diagnosis and the plan of treatment and support are indicated when there is an emergent behavioral episode.

Psychotherapeutic Interventions

Psychotherapy can be effective for persons with MR, toward realization of a variety of goals such as:

- Mitigation of stressors
- Improved coping skills
- Improved communication of feelings, problems, etc.
- Improved problem solving skills
- Improved social and interpersonal skills
- Reduction/elimination of maladaptive behaviors
- Increase of adaptive behaviors
- Understanding of disability and illness
- Increased self-esteem

Modality and Technique

Group, individual, or family psychotherapy may be appropriate for persons with MR. As with psychiatric care, the approach to treatment of mental illness in persons with MR is generally the same as for persons without MR. Techniques typically utilized with persons with mental illness can be considered potential interventions for persons who are dually diagnosed, with adaptations made as necessary, based on the needs and strengths of the individual. The approach to therapy may need to be more concrete, repetitive, and/or directive, and may need to incorporate visual and auditory aids. Role play can be effective, and behavior modification techniques, such as positive reinforcement are very important.

Generally, the lower the cognitive and adaptive functioning of the person(s), the more extensive the modifications which will need to be made in technique. Some techniques are rarely appropriate for persons who function at the lower levels of mental retardation.

Group therapy, in particular, can be an invaluable treatment approach for a wide range of emotional, behavioral and life problems. Group therapy uses the power of group dynamics and peer interaction to promote learning and development of new skills among individual group members. Group therapy can be used in promoting skills in decision making, problem solving, expression of feelings, socialization, communication, and in maintaining behavioral change.

Family therapy typically focuses on the parents' identification and support of their child's strengths and independence, and the provision of opportunities for success. Parents of recently diagnosed children need careful explanation of their child's condition. Concrete advice in management and resource finding is

important, as well as help in obtaining educational supports to which the child is entitled under federal and local laws. Parents of adolescents and young adults need help in coming to terms with emergent sexuality, and in emotionally separating and preparing them to move to out-of-family living in the community.

Behavior Therapy is based upon scientific principles of behavior and uses a functional assessment to understand the variables that influence the behavior. Generally, to be effective, behavior therapy should be applied in all settings, and include an emphasis on increasing functional replacement skills, along with the reduction of the maladaptive behavior. This approach may include adjusting the environment to reduce physical and social conditions that seem to trigger maladaptive behaviors, and various specific techniques, such as systematic desensitization, progressive relaxation, anger management, assertiveness training, and training more effective social and interactional skills.

Conjoint Therapy with or without the child present may be used to address specific behavioral issues, and allows parents or caregivers to report their observations frankly. Parents or caregivers can be supported in their efforts at behavior management, which may otherwise tend to be transitory.

Treatment Follow-up

A common problem in the treatment of persons with MR is assessing its effectiveness, which may be viewed differently by various caregivers. Therefore, discrete treatment goals should be agreed upon by the clinician and caregivers, as well as target or "index" symptoms. Interdisciplinary collaboration of professionals and caregivers is essential. Various mental health clinicians might function in the team as direct care providers, team leaders, or consultants to other professionals. Among them, clinicians with medically and psychologically oriented training are often prepared to function as synthesizers of treatment modalities of various disciplines. Followup includes service recipient interview/observation and obtaining comprehensive interim information. If the service recipient is not experiencing improvement, the accuracy and completeness of the biopsychosocial diagnosis should be reviewed, as well as the consistency of implementation of treatment by the caregivers.

TDMHDD GUIDELINE

Posttraumatic Stress Disorder (PTSD) in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents who have posttraumatic stress disorder. These guidelines are adapted from the following sources:

> *Practice Parameters for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorders*. J. Am. Acad. Child Adolsec. Psychiatry, 37:10 Supplement, October 1998
>
> Foa EB, Davidson JRT, and Frances A, eds. *The Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder*. J Clin Psychiatry 1999;60 (Suppl 16).

The user may wish to refer to the source material for complete text, annotations, and references.

Goals of this Protocol:

A. To improve the quality and appropriateness of care for children/adolescents who are diagnosed as having posttraumatic stress syndrome.

B. To aid practitioners in the difficult task of assessment and in choosing the correct treatment for each individual child. These guidelines are not intended to define or serve as a standard of medical care. Clinical management recommendations herein do not replace clinical judgment, tailored to the particular needs of each clinical situation.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

New Title 33 provisions will also require inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity to make treatment decisions. The committee process will not, however, over-ride the decision of the recipient's guardian or conservator. [2]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Assessment and Diagnosis

In order to accurately assess and diagnose a child or adolescent with Posttraumatic Stress Syndrome, the following information must be obtained and analyzed.

Interview parent or primary caregiver. (Note: If a parent is the alleged perpetrator of child abuse or domestic violence that is the identified traumatic event, the non-offending parent or other primary caretaker should be interviewed. Interview of the alleged perpetrator is not required to diagnose and treat PTSD in the child.)

Conduct careful and direct interview with the child/adolescent, using developmentally appropriate language.

Obtain report of the traumatic event(s). (Note the nature of the event, when it occurred, the parents' perception of the child's degree of exposure to the event. The parent(s) and the child both should be asked directly about the traumatic events and PTSD symptoms in detail).

Determine whether the event qualifies as an "extreme" stressor:

- The stressor must be extreme, not just severe. The event involved actual or threatened death, serious injury, rape, or childhood sexual or physical abuse. Many frequently encountered stressors that are severe but not extreme would not be included (e.g., losing a job, divorce, failing in school, expected death of a loved one).

- The stressor causes powerful subjective responses: The person experienced intense fear, helplessness, or horror.

Obtain report of any preceding, concurrent or more recent stressors in the child's life.

Stressors that may contribute to PTSD

Significant conflict, separation, or divorce	Frequent moves, school changes, or other significant disruptions
Serious accident	Child sexual abuse
Natural disaster	Child physical abuse or severe neglect
Criminal assault	Hostage/imprisonment/torture
Witnessing or learning of traumatic events	Family deaths, illnesses, disabilities, or substance abuse.

Obtain report of DSM-IV PTSD symptomatology in the child, with particular attention to developmental variations in clinical presentation.

Key symptoms Examples:

Reexperiencing the traumatic event	• Intrusive, distressing recollections of the event • Flashbacks (feeling as if the event were recurring while awake) • Nightmares (the event or other frightening images recur frequently in dreams) • Exaggerated emotional and physical reactions to triggers that remind the person of the event
Avoidance	• Of activities, places, thoughts, feelings, or conversations related to the trauma
Emotional numbing	• Loss of interest • Feeling detached from others • Restricted emotions
Increased arousal	• Difficulty sleeping • Irritability or outbursts of anger • Difficulty concentrating • Hypervigilance • Exaggerated startle response

Obtain report of any other significant current symptomatology. Give particular attention to disorders with high comorbidity with PTSD. (See Differential Diagnoses, below.)

Obtain report of whether the symptoms began prior to or following the identified traumatic event(s). (Note: This determination may be difficult if the stressor has been longstanding or ongoing; e.g., physical abuse).

Obtain report of the parents' and other significant others' emotional reaction to the traumatic event.

- Ascertain whether the parent or primary caregiver was directly exposed to the trauma (e.g., driving when a motor vehicle accident occurred) or experienced only vicarious exposure (e.g., child disclosed sexual abuse by a stranger)
- Obtain report of the presence of parental PTSD symptoms following the traumatic event
- Obtain perception of how much support has been available to the child since the event

Obtain report of child's past psychiatric history, including:

- Outpatient psychotherapy
- Partial or inpatient hospitalization
- Psychotropic medications
- Symptom course

Obtain medical history, including:

- Significant current or past medical problems, somatic complaints, surgery, significant injuries
- Current or past medications
- Current primary medical care provider

Obtain report of child's developmental history, with particular emphasis on reactions to normal stressors (e.g., birth of sibling, beginning school) and child's level of functioning prior to the traumatic stressor.

Obtain report of school history, with particular emphasis on changes in school behavior, concentration, activity level, and performance since the traumatic stressor.

Obtain report of family history and family members' medical/psychiatric history, including:

- PTSD symptoms or diagnosis
- Mood disorders
- Anxiety disorders
- Family medical conditions including any that may present as anxiety or mood disorders (e.g., thyroid disease)

Conduct interview with the child, including mental status exam

- Obtain child's report of the reason for referral

- Encourage child to describe his or her memories of the traumatic event. (Note: There is no consensus regarding the optimal degree of detail, or whether certain kinds of leading questions are helpful or harmful. Clinical consensus clearly indicates that requesting some description of the stressor from the child is desirable but that the use of highly suggestive questioning is not recommended.)

- Obtain the child's report of trauma-related attributions and perceptions about the stressor(s), including:

  → *Who or what the child believes was responsible for the traumatic event.*
  → *Whether the child believes he or she had any responsibility for causing or perpetuating the traumatic event.*
  → *Whether the child believes he or she should have behaved differently in response to the event.*
  → *Whether the child feels ostracized, damaged, or negatively judged by others as a result of being exposed to the stressor.*
  → *The child's perception of how emotionally distressed and supportive parents and significant others have been since the traumatic event.*
  → *In cases where the stressor was not public knowledge, child's perception of whether adults believed his or her disclosure of exposure to the traumatic event.*
  → *The child's perception of how "normal" his or her current symptoms are in reaction to the stressor.*

- Obtain child's report of present symptomatology, with particular emphasis on developmentally appropriate questioning regarding DSM-IV PTSD criteria symptoms. (Note: Although it is important for the evaluator to explore with the child the link between the traumatic event and PTSD symptomatology, many children may not make this connection. This should not deter the evaluator from diagnosing PTSD if the temporal relationship between the event and symptom formation as reported by child or parent supports this diagnosis.)

- Obtain child's report of symptomatology frequently associated with PTSD.

  → *Depressive symptoms, including suicidal ideation.*
  → *Substance abuse or self-injurious behavior (in older children and adolescents).*
  → *Dissociative symptoms, including fugue states, periods of amnesia, depersonalization or derealization (in older children and adolescents).*
  → *Panic attacks and other non-PTSD anxiety symptoms.*

- Observe the child for the elements of the mental status exam and for behaviors that are found with PTSD.

  → *Increased startle reaction or vigilance*
  → *Traumatic reenactment (in younger children)*
  → *Observable changes in affect or attention that may be indicative of reexperiencing phenomena*

Obtain information from school with appropriate release of information, if clinically indicated. (Note: Although school reports may be helpful with regard to confirming certain symptoms or posttraumatic changes, in many cases, school reports are not necessary to diagnose or treat PTSD in children.) Information obtained should include:

- Academic functioning with particular attention to changes since the traumatic event.
- Interactions with peers and involvement in non-academic activities, with particular attention to changes since the traumatic event.
- Temporal appearance of ADHD symptoms (i.e., present prior to or only after the traumatic event).

Determine the need for additional evaluations. (IQ testing, speech and language evaluation, pediatric evaluation), as needed and make appropriate referrals.

Consider the usefulness of standardized interviews and rating scales. Although semistructured interviews and parent- and child-rating scales of PTSD symptomatology may be helpful in following the clinical course of children with PTSD, the diagnosis of PTSD is based primarily upon the clinical interview. The use of standardized interviews and scales is not necessary to make this diagnosis.

- Semistructured interviews. The following semistructured interviews include PTSD sections; none has established psychometric properties for measuring DSM-IV PTSD symptoms in children:

K-SADS-PL	Diagnostic Interview Schedule
Structured Clinical Interview for DSM-IV	Clinician-Administered PTSD Scale for Children and Adolescents.

- Child- and parent-rating forms that may be clinically useful for following the course of PTSD symptoms in children:

PTSD Reaction Index	Trauma Symptom Checklist for Children
Checklist of Child Distress Symptoms Child and Parent Report Versions	Children's Impact of Traumatic Events Scale
Child PTSD Symptom Scale	Impact of Events Scale (Revised version for adolescents)

Differential diagnosis:

Psychiatric disorders that may be comorbid with or misdiagnosed as PTSD, or which PTSD may be misdiagnosed as.

Acute stress disorder	Adjustment disorders
Panic disorder (frequently comorbid)	Generalized anxiety disorder (frequently comorbid)
Major Depression (frequently comorbid)	ADHD
Substance use disorders (frequently comorbid)	Dissociative disorders
Conduct disorder	Borderline or other personality disorder
Schizophrenia or other psychotic disorder	Malingering
Factitious disorder	Obsessive-compulsive disorder (frequently comorbid)
Bipolar Disorder (frequently comorbid)	Social phobia (frequently comorbid)

Establish the subtype of PTSD present.

- Acute
- Chronic
- With delayed onset

If the duration of symptoms is	The diagnosis is	Comments
Less than 1 month	Acute stress disorder (not PTSD)	These are symptoms that occur in the immediate aftermath of the stressor and may be transient and self-limited. Although not yet diagnosable as PTSD, the presence of severe symptoms during this period is a risk factor for developing PTSD.
1–3 months	Acute PTSD	Active treatment during this acute phase of PTSD may help to reduce the otherwise high risk of developing chronic PTSD.
3 months or longer	Chronic PTSD	Long-term symptoms may need longer and more aggressive treatment and are likely to be associated with a higher incidence of comorbid disorders.

Psychological and Psychiatric Treatment

Formulate the treatment plan based on the clinical presentation of the child and to address both PTSD symptoms and other behavioral and emotional problems the child is experiencing.

The course of PTSD and its particular symptom pattern in different children is extremely variable. Short-term, long-term, or intermittent treatment may be required. Different levels of care (outpatient, partial or inpatient hospitalization) and modalities (individual, family, group, psychopharmacologic therapy) may be required for different children or for a given child at different points in the course of the disorder. Comprehensive treatment for PTSD is generally multimodal and may include any or all of the following components.

Treatment Strategies Include:

Psychoeducation Education of the child, parents, teachers, and/or significant others regarding the symptoms, clinical course, treatment options, and prognosis of childhood PTSD.

Individual therapy

- Trauma-focused therapy should include:
  - → Exploration and open discussion of the traumatic event; relaxation, desensitization/exposure techniques may be useful.
  - → Examination and correction of cognitive distortions in attributions about the traumatic event.
  - → Behavioral interventions to address inappropriate traumatic reenactment (e.g., sexually inappropriate behaviors following sexual abuse; self-injurious, aggressive, and other behavioral difficulties).
  - → Cognitive-behavioral techniques to help child gain control over intrusive reexperiencing symptoms.
- Insight-oriented, interpersonal, and psychodynamic therapeutic interventions may be appropriate for treating PTSD in some children.
- Therapy to address non-PTSD behavioral and emotional difficulties, in conjunction with trauma-focused interventions.

Family Therapy

Trauma-focused parental therapy should include:

- → Exploration and resolution of the emotional impact of the traumatic event on the parent.
- → Identification and correction of inaccurate parental attributions regarding the traumatic event (e.g., self-blame, blaming the child).
- → Identification and implementation of appropriate supportive parenting behaviors and parental reinforcement of therapeutic interventions (e.g., teaching parents to help the child use progressive relaxation techniques).
- → Parent training on management of inappropriate child behaviors.

- Traditional family therapy with all immediate family members for families with high conflict, harsh discipline, and/or when PTSD symptoms are present in several family members. However, family therapy generally should occur only after the child has

received individual intervention to optimize comfortable disclosure of traumatic experiences and trauma-related symptoms. No empirical or clinical consensus is currently available regarding the use of family therapy for children with PTSD.

Group Therapy

- Trauma-focused groups for children of similar developmental levels who have experienced similar traumatic exposure may be beneficial in encouraging open discussion of and appropriate attributions regarding the event.
- School-based group crisis intervention may be particularly useful in disaster situations.
- Adult psychoeducational groups may be helpful in addressing parental and/or teacher concerns following exposure of groups of children to disaster or community violence situations.

Psychopharmacology

- Antidepressants (SSRIs, tricyclic antidepressants) may be useful for children exhibiting concurrent major depressive or panic disorder symptoms.
- Psychostimulants or alpha-adrenergic agonists (e.g., clonidine) may be useful for children exhibiting concurrent ADHD symptoms.
- Antianxiety medications (benzodiazepines, propranolol) generally have not been used to treat children with PTSD. There is no current clinical consensus that use of these medications is effective for this population.

Sequencing Treatments: Whether to Start with Psychotherapy, Medication, or a Combination of Both:

This guideline provides information on the sequencing of psychotherapy and medication in the treatment of PTSD. The same questions were asked of two separate groups: psychotherapy experts and medication experts. Both groups recommended psychotherapy as a first line treatment for PTSD, but the medication experts were much more likely to combine medication with psychotherapy from the start, especially for those service recipients with more severe or chronic problems.

Age	Severity	Acute PTSD	Chronic PTSD
In children and younger adolescents	Milder	Psychotherapy first	Psychotherapy first
	More severe	Psychotherapy first* *or* Combination of medication and psychotherapy*	Psychotherapy first* *or* Combination of medication and psychotherapy*
In older adolescents	Milder	Psychotherapy first	Psychotherapy first† *or* Combination of medication and psychotherapy†
	More severe	Psychotherapy first* *or* Combination of medication and psychotherapy*	Psychotherapy first* *or* Combination of medication and psychotherapy*

*On this question, psychosocial experts preferred psychotherapy first, whereas the medication experts preferred combination treatment.

†On this question, medication experts rated both psychotherapy and combined treatment first line, while the psychosocial experts preferred psychotherapy first.

Sequencing Treatments when PTSD Presents with Psychiatric Comorbidity:

When a comorbid psychiatric disorder is present, the experts recommend treating PTSD with a combination of both psychotherapy and medication from the start. It is therefore vital that questions about comorbidity and substance use should be included in the evaluation of every service recipient with PTSD.

Comorbid condition	**Recommended strategy**
Depressive disorder	Combine psychotherapy and medication from the start
Bipolar disorder	Combine psychotherapy and medication from the start
Other anxiety disorders (e.g., panic disorder, social phobia, obsessive-compulsive disorder, generalized anxiety disorder)	Combine psychotherapy and medication from the start
Substance abuse or dependence Milder problems with substance abuse More severe problems with substance	 Provide treatment for both substance abuse and PTSD simultaneously Treat substance abuse problems first *or* Provide treatment for both substance abuse and PTSD simultaneously

Level of Care During the Initial Phase of Treatment (First 3 Months or Until Stabilized):

During the initial stage of treatment, the experts recommend that psychotherapy should generally be delivered weekly in individual sessions of about 60 minutes duration. Weekly medication visits are recommended for the first month, with visits every other week thereafter. Recommendations for treatment intensity during the maintenance phase are given in Guideline 8.
(bold italics = treatment of choice)

	Recommended	**Also consider**
Frequency of psychotherapy sessions	Weekly	Twice a week
Duration of psychotherapy sessions	60 minutes*	> 60 minutes* or 45 minutes
Format of psychotherapy sessions	***Individual***	Combination of individual and group or family therapy
Frequency of medication visits	Weekly for the first month and every 2 weeks thereafter	Weekly for all 3 months Every 2 weeks for all 3 months

*Longer sessions may be needed for exposure therapy to allow for habituation.

Selecting the Initial Psychotherapy

Brief Descriptions of the Most Recommended Psychotherapy Techniques

Anxiety management (stress inoculation training): teaching a set of skills that will help service recipients cope with stress: Relaxation training: teaching the person to control fear and anxiety through the systematic relaxation of the major muscle groups. Breathing retraining: teaching slow, abdominal breathing to help the person relax and/or avoid hyperventilation with its unpleasant and often frightening physical sensations. Positive thinking and self-talk: Teaching the person how to replace negative thoughts (e.g., "I'm going to lose control") with positive thoughts (e.g., "I did it before and I can do it again") when anticipating or confronting stressors. Assertiveness training: teaching the person how to express wishes, opinions, and emotions appropriately and without alienating others. Thought stopping: distraction techniques to overcome distressing thoughts by inwardly "shouting stop."
Cognitive therapy: helping to modify unrealistic assumptions, beliefs, and automatic thoughts that lead to disturbing emotions and impaired functioning. For example, trauma victims often have unrealistic guilt related to the trauma: a rape victim may blame herself for the rape; a war veteran may feel it was his fault that his best friend was killed. The goal of cognitive therapy is to teach people to identify their own particular dysfunctional cognitions, weigh the evidence for and against them, and adopt more realistic thoughts that will generate more balanced emotions.
Exposure therapy: helping the person to confront specific situations, people, objects, memories, or emotions that have become associated with the stressor and now evoke an unrealistically intense fear. This can be done in two ways: **Imaginal exposure** : the repeated emotional recounting of the traumatic memories until they no longer evoke high levels of distress. **In vivo exposure** : confrontation with situations that are now safe, but which the person avoids because they have become associated with the trauma and trigger strong fear (e.g., driving a car again after being involved in an accident or using elevators again after being assaulted in an elevator). Repeated exposures help the person realize that the feared situation is no longer dangerous and that the fear will dissipate if the person remains in the situation long enough rather than escaping it. **Exposure therapy can be dangerous.** It needs to be gradual and supportive and well explained and consented to by the person and parents.
Play therapy: therapy for children employing games to allow the introduction of topics that cannot be effectively addressed more directly and to facilitate the exposure to, and the reprocessing of, the traumatic memories. With PTSD this therapy needs to be directive. Otherwise, children and teens tend to either avoid dealing with the triggers and symptoms of PTSD or can become frozen in the repetition of the trauma.
Psychoeducation: educating people and their families about the symptoms of PTSD and the various treatments that are available for it. Reassurance is given that PTSD symptoms are normal and expectable shortly after a trauma and can be overcome with time and treatment. Also includes education about the symptoms and treatment of any comorbid disorders.

Preferred Psychotherapy Techniques for Different Target Symptoms

Three psychotherapy techniques—exposure therapy, cognitive therapy, and anxiety management—are considered to be the most useful in the treatment of PTSD. As shown in the table below, the experts make distinctions among the techniques depending on which specific type of symptom presentation is most prominent. Psychoeducation is recommended as a high second line option for all types of target symptoms, probably reflecting the experts' belief that it is important in the treatment of every service recipient with PTSD, but is not by itself sufficient. Note also that the experts recommend considering play therapy for certain types of target symptoms in children.

Most prominent symptom	Recommended techniques	Also consider
Intrusive thoughts	Exposure therapy*	• Cognitive therapy • Anxiety management • Psychoeducation • Play therapy for children
Flashbacks	Exposure therapy*	• Anxiety management • Cognitive therapy • Psychoeducation
Trauma-related fears, panic, and avoidance	Exposure therapy*	• Cognitive therapy • Anxiety management • Psychoeducation • Play therapy for children
Numbing/detachment from others/loss of interest	Cognitive therapy	• Psychoeducation • Exposure therapy
Irritability/angry outbursts	Cognitive therapy Anxiety management	• Psychoeducation • Exposure therapy
Guilt/shame	Cognitive therapy*	• Psychoeducation • Play therapy for children
General anxiety (hyperarousal, hypervigilance, startle)	Anxiety management Exposure therapy	• Cognitive therapy • Psychoeducation • Play therapy for children
Sleep disturbance	Anxiety management Exposure therapy	• Cognitive therapy • Psychoeducation
Difficulty concentrating	Anxiety management	• Cognitive therapy • Psychoeducation

* Treatment of choice

Preferred Psychotherapy Techniques for PTSD with Comorbid Psychiatric Conditions

The type of comorbidity accompanying PTSD affects the choice of the specific psychotherapy techniques. The experts are especially likely to recommend cognitive therapy in the treatment of PTSD when there is a comorbid mood or anxiety disorder or a cluster B personality disorder. Anxiety management is especially recommended when a comorbid anxiety disorder is present or there are substance abuse problems. Exposure therapy is also especially recommended when there is a comorbid anxiety disorder.

Comorbid condition	Recommended techniques	Also consider
Depressive disorder	• Cognitive therapy*	• Exposure therapy • Psychoeducation • Anxiety management • Play therapy for children
Bipolar disorder	• Cognitive therapy*	• Psychoeducation • Anxiety management
Other anxiety disorder (e.g., panic disorder, social phobia, obsessive-compulsive disorder, generalized anxiety disorder)	• Anxiety management • Cognitive therapy • Exposure therapy	• Psychoeducation
Substance abuse or dependence	• Anxiety management	• Cognitive therapy • Psychoeducation
Severe cluster B personality disorder	• Cognitive therapy	• Anxiety management • Psychoeducation

***** Treatment of choice

Selecting Psychotherapy Techniques Based on the Service Recipient's Age

To some extent, the choice of psychotherapy varies depending on the service recipient's age. Play therapy may be useful for children and younger adolescents. Exposure therapy is more strongly recommended for older adolescents than for children.

	Preferred techniques
For children and younger adolescents	Directive play therapy Psychoeducation Anxiety management Cognitive therapy
For older adolescents	Cognitive therapy* Exposure therapy* Anxiety management* Psychoeducation* Directive art therapy

* First-line treatment

Selecting the Next Step:

Experts contributing to the Consensus Guideline on PTSD were asked to recommend the next step when service recipients with PTSD have had no response to the initial treatment. Their first line recommendations were the same for service recipients with acute and chronic PTSD as well as for service recipients who also have suicidal or aggressive tendencies. For service recipients receiving monotherapy (i.e., medication alone or psychotherapy alone), the experts offered two general treatment recommendations:

1. Add the type of treatment the service recipient has not yet received (i.e., add medication to psychotherapy or add psychotherapy to medication) *and/or*
2. Switch to a different psychotherapy technique or to a different medication.

Both of these strategies may be helpful, either separately or in combination. Clinicians should use their clinical judgment, based on the specific situation, in deciding whether to add a new treatment, switch to a different treatment, or do both.

Presentation	**No response to psychotherapy alone**	**No response to medication alone**	**No response to combined psychotherapy and medication**
Acute and chronic PTSD	Add medication *and/or* Switch to other psychotherapy technique(s)	Add psychotherapy *and/or* Switch to another medication	Switch to another medication *and/or* Switch to or add other psychotherapy technique(s)

Strategies for Further Psychotherapy:

For a service recipient who is not responding to one of the three preferred psychotherapy techniques, the experts recommend adding one or both of the other two techniques. Adequate psychoeducation should also always be provided.

If current psychotherapy technique is	**Combine with**	**Also consider**
Anxiety management	• Cognitive therapy • Exposure therapy	• Psychoeducation
Cognitive therapy	• Anxiety management • Exposure therapy	• Psychoeducation
Exposure therapy	• Anxiety management • Cognitive therapy	• Psychoeducation

Treatment in Primary Care

Early Intervention and Prevention

What to do immediately after exposure to an extreme stressor or trauma:

- Help the service recipient understand that it is normal to be upset and have distressing symptoms shortly after a trauma.
- Provide education about acute stress reactions and PTSD.
- Encourage the service recipient to talk with family and friends about the trauma and experience the feelings associated with it.
- Educate family and significant others about the importance of listening and being tolerant of the person's emotional reactions.
- Help the service recipient and family accept the need for repeated retelling of the event in order to facilitate recovery. Provide emotional support.
- Relieve irrational guilt.
- Refer to peer support group or trauma counseling.
- Consider short-term sleep medication for insomnia.

Primary Treatment Selection

If symptoms have lasted for at least one month without significant improvement:

1. Offer or refer for psychological treatment

2. Also prescribe medication if:
   - Symptoms are severe and/or persistent.
   - Daily functioning is severely disrupted.
   - Service recipient has severe insomnia.
   - Service recipient has another psychiatric problem (e.g., depression, anxiety, suicidal thoughts).
   - Service recipient is experiencing a lot of stress.
   - Service recipient has already been receiving psychotherapy and is still having significant symptoms.

Recommended Psychological Treatments include:

- Anxiety Management
- Cognitive Therapy
- Exposure Therapy

When to Refer for Specialized Psychiatric Care

Primary care clinicians may decide to refer for specialized psychiatric care at any point, depending on how comfortable they are treating PTSD, the particular needs and preferences of the service recipient, and the availability of other services. However, referral for specialized care is often necessary in the following situations:

- Service recipient has persistent impairing PTSD symptoms that have not responded to at least one systematic medication trial, adequate in dose and duration.
- Service recipient has suicidal thoughts/behavior.
- Service recipient has had persistent problems with medication side effects.
- Service recipient has other serious psychiatric problems (e.g., depression, anxiety) that are not improving with treatment.
- Service recipient has substance abuse problems.
- Service recipient is experiencing other life stressors and/or has limited social support.

TDMHDD GUIDELINE

Schizophrenia in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with schizophrenic symptoms in primary care and behavioral treatment settings. These guidelines are adapted from the following sources:

> *Practice parameters for the assessment and treatment of children and adolescents with schizophrenia.* J Am Acad Child Adolesc Psychiatry 1994 Jun;33(5):616-35 [90 references]
>
> *The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations.* 1998. Agency for Healthcare Quality and Research, Rockville, MD. http://www.ahrq.gov/clinic/schzrec.htm

The user may wish to refer to the source material for complete texts, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with schizophrenia and aid practitioners in the difficult task of diagnosis and then choosing the correct treatment for each individual child.

These guidelines are not intended to define or serve as a standard of medical care. Many children and adolescents have comorbid psychiatric disorders, and it is necessary to consider each case individually.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or from an otherwise legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age sixteen or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

New provisions in Tennessee's mental health law, T.C.A. Title 33, will permit a provider of specified health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. When these provisions become effective by promulgation of implementing rules, acceptance of surrogate decision making will not be mandatory, and will be applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions because of mental retardation or developmental disability. [1]

1. Tennessee Code Annotated § 33-3-218 through 220
2. Tennessee Code Annotated § 33-6-107 et. seq.

Differential Diagnosis

Bipolar Disorder
Schizoaffective Disorders
Other Psychotic Disorders
Pervasive Developmental Disorders
Non-psychotic behavioral and/or emotional disorders
Organic Disorders

- delirium
- seizure
- CNS lesion
- neurodegenerative
- metabolic
- toxic encephalopathy
- infectious diseases

Developmental Language Disorders
Obsessive-Compulsive Disorder
Factitious Disorder
Substance abuse/Substance induced psychosis
Personality Disorder

- paranoid
- borderline
- schizotypal
- schizoid

DSM-IV Criteria

A. At least 2 of the following must be present for a significant period of time during a 1-month period:

- delusions
- hallucinations
- disorganized speech
- grossly disorganized or catatonic behavior
- negative symptoms (flattened affect, paucity of thought or speech)

Only one symptom need be present if the delusions are bizarre; the hallucinations include a voice providing a running commentary on the person's behavior or thinkin; or 2 or more voices are conversing with each other.

B. In children and adolescents, there is failure to achieve expected level of interpersonal, academic, or occupational achievement.

C. The disturbances must be present for a period of at least 6 months, which period must include one month (less, if successfully treated) of active-phase symptoms described above, which may include residual or prodromal symptoms.

D. Schizoaffective Disorder and Mood Disorder with Psychotic Features are ruled out.

E. The disturbance is not due to the direct physiological effects of a substance or a general medical condition.

F. Where there is a history of Autistic or other Pervasive Developmental Disorder, delusions or hallucinations are also present for at least one month (less, if successfully treated).

Evaluation

Complete diagnostic assessment including a neurologic and thorough psychiatric evaluation, school information, and history is needed, and specifically should include the following:

- Premorbid History (prenatal, developmental, personality, highest LOF)
- History of present illness (DSM-IV target symptoms; course of illness, including onset, cyclical patterns, precipitating stressors; associated or compounding symptoms, especially mood disturbances, substance abuse, and organic factors
- Physical evaluation
- Family history (environment, interactions, coping styles, resources, strengths; history of psychiatric and neurological conditions, and substance abuse)
- School functioning
- Suspected skills deficits

Rule out other disorders and determine if necessary to hospitalize.

Identify other pertinent issues that will require ongoing treatment (family dysfunction, school difficulties, comorbid disorders).

Treatment Overview

Multimodal psychotherapeutic interventions include:

1) medication management
2) periodic diagnostic reassessments to ensure accuracy of diagnosis
3) appropriate psychotherapy
4) psychoeducational services for the service recipient
5) supportive services for the family
6) educational and vocational services
7) residential services when indicated

Medication Therapy

Acute phase

Before initiating antipsychotic therapy, a thorough psychiatric evaluation is needed, which should include documentation of the psychotic symptoms targeted for the therapy. Preexisting abnormal movements should also be noted. Informed consent is needed from the parent and adolescent service recipients, while consent, when possible, should be obtained from preadolescents.

The choice of antipsychotic medication should be made based on the agent's relative potency, spectrum of side effects, and history of medication response in the service recipient and his or her family. Side effects that may occur with all antipsychotics (except clozapine) include extrapyramidal symptoms, anticholinergic symptoms, withdrawal dyskinesia, tardive dyskinesia, and neuroleptic malignant syndrome. There are also side effects specific to a particular agent, such as lenticular stippling with thioridazine, that need to be monitored when the agent is used.

When using antipsychotics, antiparkinsonian agents may be needed for the treatment of extrapyramidal side effects. Prophylactic use of antiparkinsonian agents should be

considered in situations where extrapyramidal symptoms are likely, such as when using high-potency neuroleptics, when treating new service recipients, or when treating paranoid service recipients in whom a dystonic reaction may significantly impair compliance.

First-line drugs of choice include: **Olanzapine, Quetiapine, or Risperidone.** To determine whether or not antipsychotic medication is effective, it must be used for at least four to six weeks at adequate dosages. If no effects are seen at that point, consideration should be given to changing to a different class of antipsychotic medication.

Recovery phase

Once the acute psychotic symptoms are stabilized, the service recipient may still have ongoing difficulties with confusion, disorganization, motivation, and possible dysphoria. Antipsychotic medication should be maintained through this phase to prevent acute exacerbations. The goal of therapy is to reintegrate the service recipient back to his or her home and school, if possible.

Residual or remission phase

The service recipient should be maintained on the lowest effective dose of antipsychotic medication. Once the service recipient is clinically stable, the dosages should be reassessed approximately every 6 months. Many service recipients will be chronically impaired and need to be maintained on long-term antipsychotic agents.

When discontinuing these agents, they should be tapered, given the increased risk in children for withdrawal dyskinesia. The exception to this is when neuroleptic malignant syndrome occurs. Careful monitoring is needed during times in which the dosage is being changed to assess for symptoms of relapse.

Longitudinal medication management is needed to monitor side effects, including tardive dyskinesia.

Relapse of symptoms

When a service recipient relapses, it should first be determined whether or not the service recipient was compliant with his or her antipsychotic medications. If not, resumption of the medication should occur. The drugs of choice for non-compliant service recipients are Haloperidol Decanoate or Fluphenazine Decanoate because of the availability of a depot injection every 3 weeks. **Depot injections are not recommended for children and are only recommended for adolescents with documented chronic psychotic symptoms and a history of poor medication compliance.**

If the service recipient was compliant and had been previously responding and tolerating the agent, an increase in the medication dose may stabilize the psychotic symptoms (keeping in mind the standard dosage ranges).

If symptoms relapse and the service recipient is not adequately responding to the current antipsychotic agent (while being used at adequate dosages), a trial of a different neuroleptic should then be undertaken.

Service recipients who relapse may require acute hospitalization. This decision should be based on the severity of psychotic symptoms, potential danger to self or others, degree of

impairment in the service recipient's ability to maintain basic self-care, and the availability of supportive services in the community.

Service recipients who do not respond to antipsychotics

Before it is decided that the service recipient is a non-responder, the service recipient must receive at least two adequate trials of different antipsychotic agents.

In adults, there are reports of successfully augmenting antipsychotic therapy with lithium, anticonvulsants, benzodiazepines, and fluoxetine. However, these are yet unproven and have not been studied in children and adolescents.

There are reports of clozapine being used successfully for adolescents with schizophrenia, however, in the United States, there is little experience with its use in service recipients younger than sixteen years of age. If it is to be used, close monitoring for potential seizures, agranulocytosis (with periodic blood cell counts), and weight gain is necessary.

Adjunctive pharmacotherapies should be considered in service recipients who experience persistent and clinically significant associated symptoms of anxiety, depression, or hostility, despite an adequate reduction in positive symptoms with antipsychotic therapy.

Other Treatment Modalities to be Considered

Psychosocial therapy

Support, education, and behavioral and cognitive skills training to address the specific deficits of persons with schizophrenia, to improve functioning and address other problems. Psychodynamic models are not recommended.

Service recipients who have ongoing contact with their families should be offered a family psychosocial intervention that spans at least 9 months and provides a combination of education about the illness, family support, crisis intervention, and problem-solving skills training. Such interventions should also be offered to non-family caregivers.

Psychoeducational therapy

- **for the service recipient**, includes cognitive-behavioral strategies, such as social skills and problem-solving skills, and ongoing education about the illness, medication effects, and basic life skills training

- **for the family** promotes understanding of the illness, treatment options, and prognosis and development of strategies to cope with the symptoms of the service recipient

Psychotherapy

- Individual (usually supportive rather than insight-oriented)
- Group
- Family (therapies based on the premise that family dysfunction is the etiology of the service recipient's schizophrenic disorder *should not* be used)

Treatment of associated disorders or symptoms, such as substance abuse disorder, depression, or suicidality

Partial hospitalization or day treatment programs

Specialized educational and psychiatric services available in either a hospital outpatient setting or a day treatment program that enable the individual to function at home and in community settings

Residential treatment

Severe circumstances or poor response to treatment may indicate the need for more restrictive care in an inpatient or residential setting. Less restrictive alternatives must have been unsuccessful. Ongoing assessment is needed, and the individual should return to the least restrictive treatment setting practicable, whenever possible.

Psychosocial Rehabilitation

Effective treatment may require a flexible array of services and supports, including case management, in-home services, family support, and school-based services. Supports and services of this kind are individualized and are designed to ameliorate the physical, mental, cognitive or developmental effects of schizophrenia.

Systems of care serving persons with schizophrenia who are high service users should include assertive case management and assertive community treatment programs. These programs should be targeted to individuals at high risk for repeated rehospitalizations or who have been difficult to retain in active treatment with more traditional types of services.